# SEXUAL IDENTITY, RISK PERCEPTIONS, AND AIDS PREVENTION SCRIPTS AMONG YOUNG PEOPLE IN MOZAMBIQUE

ANDREW SCOTT KARLYN


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## ABSTRACT

This thesis contributes to the understanding of young people's sexual behaviour, the normative context in which it takes place, and how implicit assumptions contained in interventions inadvertently contribute to young people's sexual risk-taking.

Fieldwork was carried out in early 2000 in Maputo, Mozambique and consisted of 71 individual and 21 group interviews with men and women aged 16-24 years old. Script theory was used as an organising framework to show how sexual culture and the social construction of risk influence the behaviour change process.

Nearly all young people interviewed were sexually active and most reported involvement in a relationship with a long-standing partner. Casual sex was common; however condom use was inconsistent with all partners. The immediate concern for young people is pregnancy, not HIV/AIDS. Two locally defined sexual identities were found. First, the survivor lifestyle demonstrates how gender and power relations define and control sexual identity and determine sexual choices among young people. Second, the *saca cena* (one-night stand) illustrates how and why some young people come to terms with risk, redefine their sexuality, and adopt innovative sexual behaviour including condom use.

Without a clear understanding of how behaviour change happens and how meaning becomes vested in practice, interventions will fail to promote healthy sexual lifestyles and prevent HIV/AIDS and STIs among young people. The gap between knowledge and practice is a case in point. Young people bridge this gap, but their response is mediated by the social and sexual identities they assume, the perceived consequences of mitigating actions, and the resources at their disposal. For the purpose of structuring effective interventions, it is important to assess what these perceived risks are, how they become integrated into sexual identities, and what resources can be deployed to modify them.

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**List of acronyms**

| | |
|---|---|
| ABC | Abstinence, Be faithful, Condoms |
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | Ante Natal Clinic |
| ARH | Adolescent Reproductive Health |
| ARV | Ante Retro Viral |
| BUCEN | United States Bureau of Census |
| CA | Community Agents |
| CAP | *Conhecimentos, Atitudes e Practicas* [Knowledge, Attitudes and Practices] |
| CDC | Centers for Disease Control |
| CSM | Condom Social Marketing |
| CVM | *Cruz Vermelha de Moçambique* [Mozambican Red Cross] |
| DHS | Demographic and Health Surveys |
| DNAJ | *Direcção Nacional de Assuntos Juveneis* [National Directorate of Youth Affairs] |
| DOTS | Directly Observed Treatment, Short-course |
| DTS | *Doença Transmitida Sexualmente* [Sexually Transmitted Disease] |
| DTS/SIDA | STI/AIDS |
| EQuAR | *Estudo Qualitativo de grupos de Alto Risco* [Qualitative Study of High Risk Groups] |
| FDC | *Fundação de Defesa de Criança* [Foundation for the Defence of Children] |
| FGD | Focus Group Discussion |
| GDP | Gross Domestic Product |
| GNP | Gross National Product |
| GRM | Government of the Republic of Mozambique |
| HBM | Health Belief Model |
| HIV | Human Immunodeficiency Virus |
| HP | *Homen Pobre* [Poor Man] |
| HPV | Human Papilloma Virus |
| HR | *Homem Rico* [Rich Man] |
| ICRW | International Center for Research on Women |
| INE | *Instituto Nacional de Estatistica* [National Institute of Statistics] |
| INPS | *Inquerito Nacional de Prevenção de SIDA* [National AIDS Prevention Survey] |
| IPC | Interpersonal Communications |
| KAP | Knowledge Attitude and Practice |
| LSMS | Living Standards Measurements Survey |
| MISAU | *Minestério de Saúde* [Ministry of Health] |
| MOD | Moderator |

| | |
|---|---|
| MoH | Ministry of Health |
| MTCT | Mother to Child Transmission |
| MZ | Mozambique |
| NAPS | National AIDS Prevention Survey |
| NGO | Non-Governmental Organisation |
| NHS | National Health Service |
| NSP | National Strategic Plan |
| OMM | *Organização da Mulher Moçambicana* [Organisation of Mozambican Women] |
| TB | Tuberculosis |
| TFR | Total Fertility Rate |
| TPB | Theory of Planned Behaviour |
| TRA | Theory of Reasoned Action |
| UEM | University of Eduardo Mondlane |
| UNAIDS | United Nations Joint Program for AIDS |
| UNDP | United Nations Development Programme |
| OVC | Orphans and Vulnerable Children |
| PEN | *Programa Estratégica Nacional* [National Strategic Plan] |
| PLWA | People Living With AIDS |
| PMTCT | Prevention of Mother to Child Transmission |
| PNC | *Programa Nacional de Control* [National Control Programme] |
| PSI | Population Services International |
| RA | Research Assistant |
| SAMP | South African Migration Project |
| SIDA | *Sindroma de Imuno Deficiencia Adquirida* [AIDS] |
| SLT | Social Learning Theory |
| SMBCF | Social Marketing Behaviour Change Model |
| SSI | Semi Structured Interview |
| STD | Sexually Transmitted Disease |
| STI | Sexually Transmitted Infection |
| USAID | United States Agency for International Development |
| VCT | Voluntary Counselling and Testing |
| WHO | World Health Organisation |

# 1 INTRODUCTION

The question of how young people in Maputo make their way in the world as young adults, and as sexual beings, is an issue of intense anxiety and debate for young people, their parents, and Mozambican society as a whole.[1] Evidence indicates that young people in Maputo, like elsewhere throughout the world, know about HIV/AIDS and how to prevent it, yet risky sexual behaviour persists. Are young people active agents engaged in a process of defining their social and sexual identity? Alternatively, do social and economic factors override the ability of an individual to make changes in their sexual behaviour? In this thesis, I trace how the agency-structure continuum is not a choice of one or the other for the typical young person in Maputo, but an iterative process of individual and societal level factors. Identity formation mirrors the process of behaviour change. Both can be seen through young people's expression of their sexuality and examined within the context of rapid social change, mediated by notions of modernity, globalisation, and the pressure of an expanding HIV/AIDS epidemic. The core question addressed in this thesis is how does behaviour change happen.

The relationship between practice and norm has been the focus of social theory since the beginning of social science as a discipline. Yet the literature on behaviour change, especially as related to health behaviours, has been widely critiqued for focusing too closely on individual factors affecting behaviours while ignoring both larger macro processes and micro interactional dynamics between sexual partners.[2] In response to this gap in the literature, this thesis will show how the behaviour change process works within the context and reality of Mozambican youth. Does practice reflect larger social norms? If so, how does practice deviate from norms and what are the consequences of such? How does practice modify norms and vice versa?

Historically, this question has been cast within the framework of the KAP Gap, referring specifically to the unmet need for family planning (Westoff 1988; Bongaarts 1991; Dixon-Mueller and Germain 1992; Casterline and Sinding 2000). The same gap has been found with sexual behaviour and HIV/AIDS. Individuals are aware of the threat of AIDS, know how to prevent it, and can obtain methods such as the male condom to prevent its transmission, yet unprotected sex persists (Anarfi and Antwi 1995; Ahlburg, Jensen and Perez

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[1] Unless otherwise indicated, Maputo refers to Maputo City and not Maputo Province.

[2] See Chapter 3 and critiques by Mann, Fluss and World Health Organization. (1991); Mann, Tarantola and Netter (1992); Ickovics, Morrill, Beren et al. (1994); Amaro (1995); Wingood and DiClemente (1996).

1997). While many have cited the deficiencies of knowledge, attitude, and practice (KAP) surveys as a source of this conundrum, implying the gap is a methodological issue rather than a conceptual one. None, however, has adequately accounted for the disconnect between knowledge and practice (Smith 1993b; Tarantola, Hannum, Boland et al. 1997; van Campenhoudt, Cohen, Guizzardi et al. 1997; Manderson, Bennett and Sheldrake 1999; Mukodzani, Mupemba and Marck 1999; Bohmer and Kirumira 2000).

I contend that young people in Maputo make the link and react to their perceived risk in measured and reasonable ways. However their response is mediated by the social and sexual identities they assume, the perceived consequences of mitigating actions, and the resources at their disposal. For the purpose of structuring effective interventions, policy makers must consider localised interpretations of risk in order to determine an appropriate response. The research presented in this thesis does not claim to provide a specific intervention plan to prevent HIV/AIDS among young people. Neither was the objective or design of the research activity to systematically evaluate project-level impact. However, it does provide insight into how one group of young people in Maputo perceives risk and acts on them. To this end, I present youth sexual practice as a social construction. I use this framework to critique several of the most commonly used individual-oriented models of health behaviour to demonstrate how and why they fail to explain youth sexual practice. Script theory is used as a tool to identify and analyse youth sexual practice from an emic perspective. By examining the contexts and patterns which lead to youth sexual risk-taking, interventions may better address the needs of young people as beneficiaries of their programmes.[3]

The data presented in this thesis comes from the EQuAR Study with fieldwork carried out from January to May 2000 in Maputo, Mozambique.[4] The activity was conducted with the collaboration and support of Population Services International (PSI) in Mozambique, an international non-governmental organisation (NGO) working in HIV/AIDS prevention and condom social marketing. The research consisted of a rapid ethnography of urban sexual behaviour and practice of young people, aged 16 to 24 years old. Participants were recruited in schools as well as in the community. A series of 71 semi-structured interviews (SSIs) were conducted over one or more interview sessions by the researcher and a team of research

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[3] Subsequent to the completion of this thesis, I question the application of studies focused on local context and highlight the overall lack of success in implementing lessons learned to programmatic interventions (Karlyn 2005).

[4] EQuAR stands for *Estudo Qualitativo de Alto Risco* [Qualitative Study of High Risk]

assistants. In addition, the team carried out twenty-one focus group discussions (FGDs) with participants using open-ended moderator guides and narrative group techniques borrowed from the PSI Project and known as the '*fogo cruzado*' peer education debate (see section 4.1.2 and Annex 11.9).

## 1.1 Research questions, objectives and structure

The aim of this thesis is to improve understanding of the sexual behaviour of young people in Africa, the normative context in which it takes place, and how this differs from the assumptions guiding behaviour change interventions. Four objectives will be met in this thesis:

1. To describe patterns of youth sexual practice in Maputo in 2000 and the risk context in which it takes place.
2. To critique the normative assumptions of one behaviour change intervention in Maputo in 2000 and to analyse the breadth and scope of interpretation of its messages by the target audience.
3. To investigate and analyse how gender and power relations in this setting define and control sexual identity and determine sexual behaviour choices among young people.
4. To understand how and why some young people in Maputo come to terms with risk, redefine their sexuality and, in the process, adopt innovative sexual behaviour, including condom use.

The overall policy contribution of this thesis is to help behaviour change interventions to respond to the needs of their target populations better.

## 1.2 The organisation of the thesis

In explaining how behaviour change works among young people in Maputo, I first document young people's sexual behaviour, the normative context in which it takes place, and how behaviour change interventions address this target group. To do so, I present a theoretical framework using script theory to demonstrate how sexual culture and the social construction of risk shape implicit assumptions about how behaviour change happens, both in terms of individual actions and that of change agents which impose external models of risk assessment. Further, the risk contexts identified in this research not only document the sexual practice of young people in Maputo, but their sexual identity as a function of risk perceptions and the capital resources at their disposal to mitigate such risk. Risk avoidance as well as risk-taking

can affirm one's position within a group, as well as function as the boundary for exclusion from others, which ultimately comes to shape individual and group identity.

To examine how the behaviour change process works within the context and reality of young people in Maputo, I examine how young people in Maputo perceive the risk of HIV/AIDS and other threats, and subsequently how they act on these perceptions. What are the contexts and patterns which lead to sexual risk-taking? What is the context of the HIV/AIDS epidemic, prevention efforts, and young people's sexual health in Maputo? Does the severity or social proximity of the HIV/AIDS epidemic in Mozambique directly affect young people's sexual choices?

Script theory, as applied to the question of risk and sexual practice, is particularly well suited to examine the relationship between agency and structure in guiding individual and group practice. Through script theory, I pose the question: are young people active agents engaged in a process of defining their social and sexual identity or powerless victims of social and economic factors which override the ability of an individual to make changes in their sexual behaviour? In the process of examining this question, I examine how social norms shape individual behaviour, and in turn, how everyday practice comes to shape norms.

Script theory was chosen as the key organizing framework for this thesis due to the fact that the study was conducted in a programme intervention context. A large set of stakeholders, from a variety of backgrounds and institutions, were involved in the planning and approval of the study design. Script theory offered an excellent compromise since it is founded in practice theory with direct behaviour change theory linkage. On a practical side, script theory was easily understood by programme managers and MoH counterparts, thus contributing to 'buy-in' on their part. In addition, the use of script theory does not excessively constrain the methods employed in this thesis by limiting complex processes of sexual interaction into a neat, predictable model. Rather, scripts are a metaphor for how individuals, in the context of a dyad (couple), come to make sense of the confusing and contradictory ritual of relationship formation and sexual practice. Ultimately, script theory assists this investigation by capturing both the personal and interpersonal characteristics of sexual interactions at a given point in time.

Chapter 1 introduces the reader to the research question posed by the thesis, as well as the objectives and policy implications therein. The thesis focuses largely on innovators as the vanguard of behaviour change among young people in Maputo.

Chapter 2 seeks to understand the context in which young people come to terms with their sexuality. The chapter sets the scene by reviewing the challenges young people in Maputo face in terms of their sexuality, HIV/AIDS, and the social and economic pressures placed on them. The chapter trace the distal and proximate factors influcing sexual risk taking among young people in Maputo.

Chapter 3 presents the analytical framework used throughout the thesis, risk as social construction. In the first section, the chapter documents how and why practice and norm formation are relevant to AIDS interventions and how HIV/AIDS is socially constructed. The implications of HIV/AIDS as a social construction are considered as well as the role of risk in such constructions. In the second half of the chapter, I document how other models of health behaviour explain risk associated with HIV/AIDS, highlighting their limitations. As an alternative, I present script theory to explain risk practices in the context of a behaviour change intervention.

Chapter 4 presents the research design and methods used, taking into consideration the special circumstances of addressing sensitive issues such as sex, death, and violence. I document my role as both researcher and intervention agent. The challenges and limits of the design and methods used are then documented. Finally, the methods used to analyse the data collected are described.

Chapter 5 presents the basic results obtained from the fieldwork, focusing principally on perceptions of risk and change among the young people surveyed. The first section of the chapter presents the common characteristics, anomalies, and larger trends in sexual practice found. The chapter traces trends in sexual behaviour by socio-demographic characteristics of participants as well as by age, school attainment, residency, mobility, employment, and household size. The sexual activity of the participants is explored, including relationship duration, children, number of partners, and relationship types. The topic of condoms is discussed. The chapter next explores what motivates sexual risk-taking and documents the contexts that drive sexual behaviour based on perceptions of risk and sexual meaning adopted by young people over their sexual careers. Participants express their own perception of sexual risks including unwanted pregnancy, modes of prevention, condom use, partner types, and sexual pressure. Lastly, the chapter explores participants past formative events as they relate to current sexual practice.

Chapter 6 presents an analysis of the risks represented by young people and the ways in which social change interventions attempt to address such risks. Here, script theory is used to show how risk is embedded in the sexual scripts driving sexual practice. Gender ideologies shaping risk perceptions are presented with the accompanying gender roles that perpetuate risk perceptions and ultimately limit the ability of young people to explore protective practices. Next, I identify the implicit assumptions shaping intervention activities directed at young people and demonstrate the ways in which interventions reflect a biased reality of youth sexuality. The section then explores how interventions can lessen the risk associated with sexual interaction among young people in Maputo. Lastly, the chapter turns to young people's perceptions of interventions and the risk messages directed at them. The question is posed whether safer sex messages are appropriately directed toward young people, and whether they respond to their concerns and needs. Finally, Chapter 6 examines if young people's sexual practice has changed because of interventions in Mozambique.

Chapter 7 examines the role of sexual scripts in regulating gender roles. The first half of the chapter examines on the process of social learning which teaches dominant scripts of masculinities and femininities. Topics examined include how gender norms are formed, perpetuated and regulated, what role they play in defining youth sexuality. Subsequently, the chapter turns to how gender norms function as a mechanism of social control and resistance among young people in Maputo. Specifically, the issue of sexual violence as a form of social control is examined, the role of transgression in defining boundaries of social control, and how transgression has come to be used as a tool to challenge dominant gender sexual scripts.

In Chapter 8, innovation in sexual behaviour is examined through the lens of one sexual practice, the *saca cena*. The phenomenon is described in detail as a nascent mechanism of behaviour change and placed within the context of local risk discourse, sexual practice, and changing cultural scripts. The chapter considers whether the *saca cena* is a new source of risk of HIV/AIDS for young people or an existing practice altered to accommodate new meanings of sexuality, gender power relations, and social interaction. In the second half of the chapter, the topic of the *saca cena* is further developed to consider how the practice has contributed toward the reconfiguration of power relations between men and women. I consider how the *saca cena* challenges the dominant discourse of sex for reproduction, economic security, and emotional intimacy. I also show how the *saca cena* is an adaptive response to the threat of HIV/AIDS which resolves competing notions of risk and the need of young people for both sexual experimentation and protective practices. In doing so, I demonstrate the role the *saca cena*

plays as an outlet for expressing sexual desire and pleasure while functioning as a social prophylaxis to protect from damage to one's reputation, the break up of stable relationships, and exposure to STIs or HIV.

Finally in Chapter 9, the thesis concludes with an assessment of the theoretical and policy level contributions of the findings presented. The principal policy question presented in the thesis is how to promote behaviour change to prevent transmitting HIV/AIDS. The underlying premise guiding this question is whether interventions can effectively promote behaviour change. Can interventions adequately reflect the needs of their target population without recognising their own internal biases towards individual models of behaviour change? At the same time, can interventions incorporate local beliefs and practices which determine how young people perceive risk?

## 2 SETTING THE SCENE: HIV/AIDS AND THE SEXUAL HEALTH OF YOUNG PEOPLE IN MAPUTO

In the past 15 years, Mozambique has experienced a steady and growing HIV/AIDS epidemic. Approximately 1.4 million people, or 8% of Mozambique's population, are currently infected with HIV as of 2002. Recent prevalence data indicate that 13.6% of sexually active adults aged 15 to 49 in Mozambique are HIV positive as of 2002 (MoH 2003). In Maputo, the epidemic has accelerated significantly since 1998, with prevalence rates increasing from 10% to the current level of 17.3% (UNAIDS 2002b; MoH 2003). At the time of the fieldwork in 2000, the residents of Maputo were just waking up to the severity of the epidemic.

Over 500 new infections and 220 deaths due to HIV/AIDS occur daily.[5] Life expectancy will decrease from 50.3 to 35.9 years by 2010. Higher rates of infection are found in young women 20-24 years-old and in men in their 30s and 40s (Barreto, Mac Arthur, Saúte et al. 2004). The focus of this thesis is thus limited to the time period of 1995 to 2000. When available, more recent data are provided. Likewise, historical information is given to contextualise the findings.

To understand the factors contributing to the rise of the epidemic in Maputo and the corresponding actions taken by young people to mitigate exposure, I use this chapter to identify both the distal and proximate factors contributing to the AIDS epidemic in Mozambique. The distal or underlying factors include poverty, poor health, social dislocation, and migration. The latter is exacerbated by Mozambique's historic position as both a labour reserve and transport conduit for the interior of southern Africa. The proximate factors which have made Mozambique especially vulnerable to the spread of HIV/AIDS include poor health service delivery, a pre-existing and concurrent STI epidemic, and gender power relations marked by the physical and emotional subjugation of women. In exploring the root causes of AIDS epidemic, I document how the epidemic has spread and the current levels of HIV prevalence recorded in country. I also describe how NGOs have responded to the epidemic in the form of AIDS prevention programmes. These are either government led or sanctioned activities carried out through NGO partners. One such intervention will be considered in detail, the *Jeito* Condom Social Marketing programme, implemented by PSI. The *Jeito* Project will be used as an example of how the prevention discourse was structured around individual deterministic models

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[5] It is estimated that only 9% of actual cases are captured through the 'passive' notifiable desease surveillance system of the Ministry of Health (MoH 2004), pp 11.

of behaviour change, while providing the background for future discussions of PSI's interventions.[6] Finally, I will present how behaviour change interventions have largely failed to stem the rise of the epidemic in Maputo.

### *2.1.1 Distal factors: Structural influences on the health of young people in Maputo*

Poverty

Mozambique is a desperately poor country with 38% of the population subsisting on less than $1 per day and a GDP per capita of $200 (UNDP 2003). When adjusted for purchasing power parity, this figure is estimated at $800 per capita (World Bank 2002). Mozambique has endured a devastating series of conflicts, including the colonial war for independence from Portugal which ended in 1975 and the subsequent civil war ending in 1992. This left Mozambique among the world's least developed countries both in terms of economic and social indicators. While measures of poverty are controversial and evolving, by all accounts poverty in Mozambique is highest in the north and improves gradually as one moves south. Maputo is decidedly less poor than other areas of the country (Tarp, Simler, Matusse et al. 2002). This is because of direct foreign investment which has benefited a growing number of urban dwellers by increasing access to wage employment, improved housing and sanitation, better educational opportunities and health facilities. Nevertheless, the impact of structural adjustment on the urban poor has been detrimental for the majority in part because of the size and high population density of Maputo and its peri-urban shantytowns. While green zones around the city exist, access to land for subsistence cultivation is limited. Dependency ratios are high with only 30% of the population formally employed (Jenkins 2000b).

Despite the pervasive poverty, at the time of this study, HIV/AIDS could still be considered an illness of the wealthy in Mozambique. This pattern has been documented throughout southern Africa, where the symbols of wealth –crudely known as the '3 Cs' (cash, car, and cell phone) – form the incentive for impoverished women to trade sex for material and social status gain (Vandemoortele and Delamonica 2000). Post war recovery created conditions for rapid growth. Mozambique was one of several countries in sub-Saharan Africa where per capita income grew by more than 3% a year between 1995 and 2000 (UNDP 2003).

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[6] The terms PSI, *Jeito (pronounced 'jay-to'*, Project, Activity, and Intervention are all used to describe the same activity.

Health infrastructure and service delivery

Mozambique's health sector and infrastructure was completely decimated by the war. The physician to patient ratio is 0.03 per 1,000 people (World Bank 2001). By 1997, the reconstruction of National Health Service (NHS) facilities reached only 75% of the levels existent at the end of the colonial period (Cliff 1998). Even then, the health coverage at independence reached less than 10% of the population. To correct this situation, the newly independent Government of the Republic of Mozambique (GRM) embarked on an ambitious restructuring of the health system guided by a state dominated socialist model. All health services and facilities were nationalised and controlled through a central planning system. The revised pharmaceutical policy adopted a list of essential drugs emphasizing generic drugs and standardized therapeutic regimes for STIs (Walt and Melamed 1983).

Nevertheless, the health sector like other state-sponsored activities suffered from a regional bias which favoured urban areas and the most southern provinces. This uneven development has its genesis in the colonial state, although the ruling elite which predominately originate from the south have perpetuated these distortions. These inequities can be seen in terms of infrastructure, human resources and investment, even though most of Mozambique's population lives in the northern and central provinces.

Since independence, various efforts and initiatives have been made to redress this imbalance and thus improve the health care situation all over the country. One major innovation relevant to this thesis was the introduction of structural reforms in the health sector through the use of market mechanisms such as cost recovery measures for public clinics and the privatisation of medicine allowing for private practice (for and not-for-profit). The purpose of the reforms was to introduce efficiencies in the sector to improve health service delivery and redress the geographical bias plaguing the system. Despite these reforms, financial, physical, and human resources continue to be biased against rural areas and northern regions of the country. Differences in levels of infant mortality and communicable diseases between regions reflect this inequity (DHS 1997a).

The move toward private mechanisms for providing basic health services was less an ideological shift by the GRM than a necessity given the harmful effects of prolonged drought, economic mismanagement, war, and conditionality imposed by the World Bank and other major donors. All combined, this resulted in the delayed reconstruction of local health infrastructure (Buse and Walt 1997; Pavignani and Durao 1999). To fill the void in health

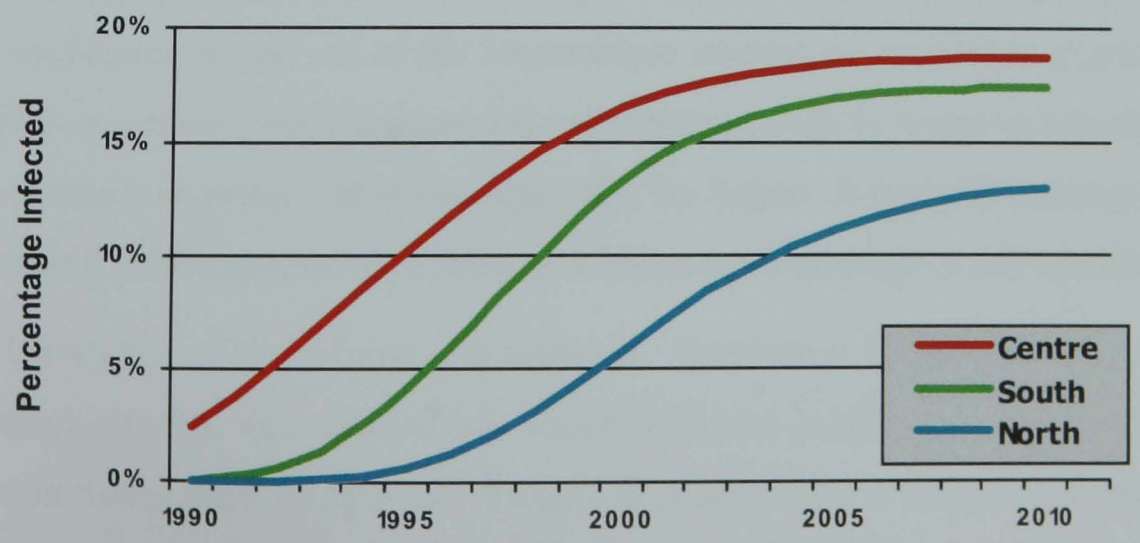
service delivery, donors sponsored international NGOs to provide health services, often to the detriment of sustainable health service. The lack of coordination, duplication of activities, distortions in the human resource base, and conflicting standards and systems all left the NHS in disarray. Most importantly, the opening of the public health sector to private entities paved the way for the HIV/AIDS prevention strategy which dominated the second half of the 1990's – condom social marketing (CSM) (Pfeiffer 2004).

Migrant labour

Mozambique is an important east-west transport hub for goods moving in and out of southern Africa via the Maputo, Beira, and Nacala transport corridors. Road and rail links running north-south are significantly less developed and hinder the movement of populations between regions in the country. The garrisoning of foreign troops, principally Zimbabwean, along the Beira corridor during the 1990s, played an important part in fuelling the spread of HIV in Mozambique in the early days of the epidemic. Further, a large number of refugees (estimated at 1.5 million) fled to neighbouring countries where high rates of HIV had been recorded in the general population. The refugees returning at the end of the war had higher rates of HIV and STIs than the receiving population as a whole (Cossa, Gloyd, Vaz et al. 1994).

Along the Nacala Corridor in the north, there was less access during the war and the presence of Mozambican and Malawian troops was limited to the corridor itself. With the exception of the areas bordering Malawi where small-scale traders could travel, prevalence rates were slow to climb. In the south, a similar situation is found whereby the opening of trade links with South Africa has been the major driving force of the epidemic. Since the same strain of the virus is found throughout Mozambique, this pattern supports the theory that Mozambique is suffering one epidemic, but with three independent trajectories (Foreit 1999).

***Graphic 1 : HIV Prevalence among adults, 15 - 49 years old, by region of Mozambique***




Source: (MoH 2003)

Regional labour movements form an important part of the economy of southern Mozambique, and have done so for centuries. The east-west integration of economic networks served not only to move goods, but also cheap labour from proscribed labour reserves in southern Mozambique, and formed part of a larger strategy of South African mining houses to exploit regional labour pools. In Mozambique, this reserve was defined as the region South of Save River (Parallel 22). By the 1970s, mine employment was the single most important source of Mozambican wage labour. An average of 110,000 migrant workers worked in the South African mines, principally gold mines. According to the 1980 Mozambican census, 6% of men in Gaza Province were reported as migrant mine workers (Barreto, Foreit, Noya et al. 2002). Mine remittances formed an important source of state revenue since they were channelled through state coffers and thus subject to tax, exchange differentials, and theft. Mine income far outstripped the income earned from other activities in the region, including commercial agriculture. However, by the mid-1970s, the number of Mozambican mine workers dropped from 118,000 in 1975 to 41,300 in 1977 (Castel-Branco 2002).

Since then, formal sector labour migration has varied between 30,000 and 48,000 workers at any given time, although the trend since the mid-1990s has been one of decline at an average of about 2% per year. However, the flow of migrants continued in the form of illegal migration to South Africa. Although precise numbers are impossible to obtain due to the illegality of the population movement, it is estimated that over 4,000 young people cross over the Ressano Garcia border to South Africa weekly (Monjane, Uamusse, Osório et al. 2003). Estimates place between 10,000 and 80,000 Mozambican migrant labourers working on commercial farms in the Lowveld of Mpumalanga Proving, South Africa. (Crush, Mather, Mathebula et al. 2000). Accordingly, the value and relative importance to Mozambique's GNP has declined. Between 1990 and 2000, formal sector remittances declined from $70 million to $37 million, representing 23% and 5% of foreign currency earnings respectively. By 2000, the flow of remittances in and out of the Mozambique reached an equilibrium (Castel-Branco 2002). Thus at a macro level, it appears as though remittances are no longer an important factor in Mozambique's economy. However regionally, the impact of external remittances on the livelihoods and social organisation of residents in southern Mozambique is still significant.

The impact of this collapse is widespread. Remittances formed the basis of capital accumulation and thus their absence has undermined rural livelihoods. The lack of wage employment forced many to seek their fortunes in South Africa in the informal sector, thus creating a large and uncontrolled migrant stream. The loss of wage labour also disrupted

marriage patterns and concomitant forms of social reproduction. As young men lacked the ability to accumulate capital necessary to pay bride-wealth, non-formal cohabitation often supplanted marriage but without the associated social obligations. The loss of economic opportunity in South Africa had widespread implications for the population of Maputo as well. It coincided with independence and the lifting of pre-existing controls on population movements. Inward migration to Maputo from the surrounding region increased the population of Maputo to 755,000 by 1970, which represents a 97% increase from the previous census 10 years prior. The current population of greater Maputo is estimated at 1.5 million (Jenkins 2000a).

Economic growth

In the past 10 years, Mozambique has enjoyed an unprecedented economic boom across sectors – especially small-holder agriculture. This has opened trading networks from primary to secondary and tertiary roads, resulting in the sexual mixing of populations from the main transport corridors to well within the interior of the country (Bowen 2000). Traders tend to be the vanguard of the HIV/AIDS epidemic and in Mozambique this was no exception. Small-scale itinerant traders, both men and women, traversed the region within Mozambique and to neighbouring countries. With them they took goods such as agricultural produce including maize, beans, and dried fish. In doing so, traders amass large quantities of cash and were often at the mercy of officials (police, border guards, customs officers, military, etc) who would demand bribes and sexual favours in exchange for free passage (Bowen 2000). This is compounded by the well-established behavioural pattern of traders who have money in their pockets, spend long periods of time away from home, and frequent marketplaces where both alcohol and commercial sex are commonly found (Pickering, Okongo, Bwanika et al. 1996).

The collapse of the formal mining sector has made South Africa no less important to the social and economic development of southern Mozambique. Large capital projects contributed significantly both to the economic growth of the south as well as HIV/AIDS epidemic. The MOZAL aluminium smelter and upgrading of the Witbank (SA) to Maputo transport corridor into a concessionary toll road has hastened the integration of southern Mozambique with South Africa (Castel-Branco 2002). In many ways, these large investments have transformed the south of Mozambique. Since the road upgrade to South Africa, it now takes only one hour to drive from Maputo to the border, removing many of the physical and administrative barriers impeding small and large-scale trade between the two countries. The construction of the MOZAL smelter has created many jobs for both Mozambicans and South

Africans as expatriates in Mozambique. The satellite industry around the smelter has also grown, to include bars, restaurants, small shops and kiosks. These venues supply the auxiliary goods and services demanded by the workforce, including alcohol and commercial sex (Epstein 2002).

Changes in social relations

As we have seen at the beginning of this chapter, Maputo has undergone dramatic changes in the past 25 years. It is a familiar scenario for post-independence countries in sub-Saharan Africa, where rapid structural changes occur due to post-war political and economic reforms (Jenkins 2000a). Mozambique attempted to transform overnight a primarily agrarian, mercantilist colony into a state-directed industrial economy based on an ideology of scientific socialism. This state-led project ended disastrously under the combined weight of apartheid South Africa's policy of destabilisation, economic mismanagement, drought, and alienation of traditional elements of society. For urban Mozambicans, the cost of this change was the "denial of African culture in the name of modernisation" and resulted in the breakdown and reconfiguration of the "structure of local social organisation" (Lundin 2000:3).

While the change in the political and economic regime of Mozambique and later South Africa was abrupt and definitive, corresponding changes in social relations have been less explicitly directed. Giddens (1990; 1991) suggests the family has yet to fully adopt the democratised ideals of the modern family, of gender equality, and protecting children. However, while this may explain the transition to modernity in Western Europe and North America, Giddens' construct of the family and change does not necessarily fit well with the historical experience of Southern Africa. In the Mozambique experience, the fluidity between rural and urban, traditional and modern has historically placed young people in precarious and uncharted situations. The reconfiguration of novel forms of social integration has emerged, with African Independent Churches (AIC) filling this gap in part (Pfeiffer 2002; 2004; Agadjanian 2005), as well as non-secular outlets for the creation of social identity among young people. Informal migration to South Africa is such an example. It has become a rite of passage for young Mozambican men, and increasingly women, however not without cost. The fragility of Mozambicans' status as illegal immigrants in South Africa has placed them at increased risk for discrimination, abuse, and deportation (First 1983; de Vletter 1998; Wojcicki and Malala 2001). In addition, forced migration can be considered a contributing factor toward sexual exploitation and violence, and heightened morbidity including STI/HIV (Cossa, Gloyd, Vaz et

al. 1994; Barreto, Foreit, Noya et al. 2002; Sideris 2003; Hargreaves, Collinson, Kahn et al. 2004).

The weight of mass media predominant in the urban environment encourages young people to engage in adult activities, be they smoking, drinking, sex, work, play etc. (Galavotti, Pappas-DeLuca and Lansky 2001; Wingood, DiClemente, Harrington et al. 2001). The information that young people receive about sexual health often comes after they have become sexually active, with conflicting messages leaving young people at odds with social norms of sex as glamorous and the view of adults unwilling to engage in serious debate about youth sexuality (Aggleton and Campbell 2000). The combined burden of poverty and AIDS has forced many young people in the southern Africa region to become caretakers of parents ill with AIDS or guardians of siblings orphaned by the disease (Young and Ansell 2003).

The lengthening period of adolescence is one outcome of modernity with potentially negative ramifications. Across Africa, delay in marriage coinciding with a fall in age of menarche resulted in an increase in the number of years spanning the two events (Savage and Tchombe 1994). Thus there are more sexually active, unmarried young people than ever before (Gage-Brandon and Meekers 1993; Blanc and Way 1998; Bongaarts and Cohen 1998). With changes in timing, the meaning of menarche and spermarche has also changed across cultures (Balmer 1994; Barker 2000). In Mozambique, the age of menarche has fallen among urban girls from 13.55 in the 1960s to 13.2 in 2000. Significant differentials based on urban residence and educational attainment of parents have been documented as well (Padez 2003). Historically, in traditional cultures found in southern Mozambique, a young girl would be promised by means of *lobola* (bride wealth) soon after her first menses. For young men, marriage would come later so they could accumulate the necessary capital (cattle) to pay bride wealth (Rita-Ferreira 1961; Junod 1962 [1912]). It is not uncommon for cultures to control young women's behaviour once she reaches menarche. Boys on the other hand, are given much more freedom, though still may not receive the necessary information about physical and emotional changes they are experiencing (Barker 2000).

Intergenerational communication on the topic of sex is a good example of the impact in changes in social relations. With the period between puberty and adulthood becoming longer, young people need information, support and counselling to prepare them for changes in their sexuality and importantly for preventing HIV/AIDS. In Maputo, as elsewhere, the strength of the idealised modern nuclear family as an ideal social, economic, and moral construct, has placed the responsibility of sexual education squarely on parents despite the strong cultural

taboo against it (Fuglesang 1997). While widely thought of as predominantly macro processes, globalisation can be seen as a micro project which entails the "transformation of everyday life, of the nature of self, of the nature of our emotions, of the nature of how you construct local solidarities, how you construct friendships, how you construct sexual relationships, and how you construct a relationship between parents and children." (Giddens 1999:15).

Historically, rites of initiation in Mozambique provided a moral education for young people, however the practice has diminished greatly both in frequency and content (Santos and Arthur 1993b). Traditional moral education is still provided to some in southern Mozambique, with girls taught by elder woman called *massungukatis.*[7] Boys are given instruction in traditional ways by elder men called *madhodhas* (Monjane, Uamusse, Osório et al. 2003).[8] However, the use of these traditional counsellors has largely fallen by the wayside for most urban and many rural dwellers. As a result, there has been a virtual break down of ritual communication of sex education, formerly provided by community elders (Bagnol 1996; Bukali de Graça 2002). Instead, it has been replaced by silence, shame, and abdication of responsibility toward young people's reproductive health needs. Where traditions continue, they do so in a syncretic manner, potentially changing the meaning and function of the practice. The recreation of traditional practice has developed in response to the HIV/AIDS epidemic (Leclerc-Madlala 2001; Muyinda, Nakuya, Pool et al. 2003). In much of urban southern Africa, ritual circumcision of boys continues to this day. Aside from the intrinsic validation of culture, practices of initiation such as male circumcision offer considerable protection against STIs, including HIV (Halperin and Bailey 1999; Bailey, Muga, Poulussen et al. 2002).

The controversy over how young people express their sexuality in Mozambique as elsewhere masks larger issues of conflicts in social interaction and intergenerational communication. Like elsewhere, conflict over youth sexuality often focuses on the promotion of condoms. Studies in Mozambique have focussed on various factors thought to inhibit condom use including societal-level factors such as social networks (Agadjanian 2001b; Agadjanian 2005), globalization (Pfeiffer 2002; 2004), class (Machel 2001); and individual-level factors (Agha, Karlyn and Meekers 2001; Karlyn 2005; Manuel 2005).

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[7] Woman counsellors selected by communities and families based on their age, knowledge, and ability to instruct young girls about traditional practices.

[8] Older men selected by the community and family who are deemed capable of instructing youth on issues of traditional culture and leadership.

Underlying these conflicts over condoms is the perception by parents and conservative segments of society that young people are promiscuous, pleasure-seeking, irresponsible, and short-sighted (Rivers and Aggleton 2001). By contrast, young people see their parents as anti-modern, traditionalists who cannot understand them nor feel open about talking about sexuality. Thus sexuality is a flash point for larger social divides, born of misunderstandings, power, and mistrust. The over-arching classification of young people as adolescents is emblematic of this divide. Adolescence refers to a specific stage of their physical, emotional and social development.[9] The storm and stress model of adolescent development, which has persisted despite a lack of supportive evidence, fails to consider the heterogeneity and contextual basis of young people's development (Arnett 1999; Ayman-Nolley and Taira 2000). This does not deny that young people do experience considerable conflict in their lives, especially in transition societies undergoing rapid modernisation. However the principal basis of this stress is not biologically driven, but socially constructed (Lesko 1996; Arnett 1999; Bakaroudis 2003).

Adolescent sexuality is still largely defined by socio-biological discourses (Ayman-Nolley and Taira 2000; Rivers and Aggleton 2001). Investment theory states the stability of relationships correlates with the number of investments in the relationship (children, shared possessions, and years together) (Sprecher 1998). Reiss (1967) identified four premarital sexuality standards: abstinence, permissiveness with affection, permissiveness without affection and the double standard. The have-hold discourse, permissiveness with affection, is a most common sexual discourse today in the West. Heterosexual sex consists of three dominant discourses: 1) the male dominant sex drive where men are biologically driven by their libido and women are compliant, passive objects there only to satisfy male needs. 2) A woman must save herself for the fittest male and thus charged with controlling the pace, timing, permissible acts, and results of the sexual encounter. 3) The permissive discourse guarantees an equal entitlement to casual sex for both men and women. The emotional investment is minimal. Sexual access does not depend upon disclosure, intimacy, honesty or trust (Reiss 1967). It describes a couple in a committed relationship, based on a contract (marriage) of trust, exclusivity, and fidelity. The male sex drive dominates in exchange for exclusive sexual access (Ingham and van Zessen 1992; Crawford, Lawless and Kippax 1997).

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[9] In this thesis, young people and youth are used interchangeably to refer to individuals between the ages of 14 to 25 years old. While somewhat arbitrary in terms of cut-offs, this age group encompasses early adolescents (12-14 year olds), adolescents (15-19), and young adults (20-24). I refer to adolescents only when specifically discussing the physical, social and psychological development of 14-19 year olds.

In Mozambique as elsewhere in sub-Saharan Africa, parents generally do not talk about issues of sexuality with their children nor is there a historical tradition of parent-child intergenerational communication on this topic. Instead parents in Mozambique have turned to proxy institutions such as schools and organised religion to provide moral and factual information about sexuality (Pfeiffer 2002). A similar pattern of proxy parenting has been found elsewhere (Wellings, Wadsworth, Johnson et al. 1995). Young people are quick to recognise the hypocrisy in their parents' admonitions to do as they say and not as they do. For instance, young women see older men as a source of danger as well as opportunity.[10] Young men, on the other hand, cannot compete with older men who have resources and often resort to other means of winning over a partner, including coercion.

Young people are thus trying to make sense of their sexuality in the midst of dramatic changes in family composition, household forms, and the structure of authority. Youth culture, by definition, is fluid and dynamic. It is mediated by exposure to mass media, mobility, and social change; all of which combine to create an unique set of rules that regulate how young people must behave (McCool, Cameron and Petrie 2001). In the last 10 years, educational, material, and social aspirations have been widely democratised in Mozambique. Yet like other contexts undergoing rapid social change, expectations are subject to considerable degree of pressure from parents, peers and society (UNAIDS 1999b).

Not all change, however, impinges negatively on young people's reproductive health. For instance, the increased availability of modern contraceptives combined with information and education have contributed significantly to women's desire for fewer children. Agadjanian (2001a) demonstrates this trend in Maputo, and points out that informal peer networks as alternative forms of social organisation, play an important role in supporting women's decision to use family planning. Such change is reflective of the social, political, economic, and demographic transformations Mozambican society has undergone (Agadjanian 2001a).

Changes in expectations also extend to reproductive health practices, including the use of contraceptives and sexual practices. It is commonly accepted that young people create their own meanings and expression of sexuality, despite tradition. Furthermore, policy-makers implore that interventions should take into account how youth sexuality reflects a divergence from traditional sexual norms, and thus changes in sexual practices (Paiva, Ayres and França Jr.

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[10] An urban myth heard in Maputo is that of an older man who picks up a young girl in a dark nightclub. After many drinks, they go to a hotel to have sex. When he wakes up the next morning he realises that he has just slept with his own daughter.

2004). Parents, educators, and health providers often fail to recognise that young people are coping with expectations of abstinence during a prolonged period of adolescence. Moreover, young people see through the guise of societal concern for their sexual health.

> Exhortations to abstinence or delayed sexual activity are resisted by many young people and seen for what they are – moral agendas dressed up as health promotion (Senderowitz 2000:21).

### 2.1.2 *Proximate factors: The sexual health of young people in Maputo*

Against this backdrop of underdevelopment, young people's attitudes and behaviours in Maputo reflect the pervasive and often conflicting influences of modernity, globalisation, poverty, forced migration, and educational access. All of these have a profound influence on youth sexuality and risk of contracting HIV/AIDS or an STI. In the next section, I review the topic of youth sexuality in Maputo to demonstrate its heterogeneity in terms of sexual practice, formative experience of adolescence, and multiple gender identities associated both with masculinity and femininity. Further, I document how young people suffer from negative health outcomes due to early pregnancy, as well as the burden of communicable diseases including STIs and HIV/AIDS. Finally, I provide what little information exists on the topic of forced sex due to coercion and rape, as well as safer sex practices documented in Mozambique.

Basic health indicators

Of a population of over 19 million, nearly half of Mozambique's population is under the age of 20 years old and a third lives in urban zones (34.3%).[11] Adult literacy is 46.5%, 31.4% for women and 62.3% for men. Primary school enrolment is 91.5%. The total fertility rate (TFR) is 5.69 and contraceptive prevalence rate using modern methods for all women is 18.4%. The median age of first penetrative sex by women aged 25-49 is 16.1 years and 67.8% of women 20-24 years old gave birth before age 20. The percentage of pregnant women who had at least one antenatal check-up by a health professional is 84.2%. Infant mortality rate is calculated at 125 per 1,000 live births. Under five mortality rate is 180 per 1,000 live births. The estimated number of cases of tuberculosis is 79,144 in 2000, with a case detection rate of 40% and DOTS success rate of 71%. Annex 11.2 presents a comprehensive set of socio-demographic indicators and their sources (USAID 2003).

[11] Population data are adjusted from the 1997 census at a growth rate of 1.6%.

Heterogeneity of sexual practice

Young people in Maputo, as in many other urban African settings, exhibit a high degree of variation and experimentation with regard to sexual practice, and engage in casual sex at a relatively early age (Karlyn and Monjane 1998; Agha, Karlyn and Meekers 2001). Common sexual practice includes vaginal, oral, and anal intercourse. The latter practice is significant, since the deviance associated with the practice marked relationship type such that one cannot have anal sex with a main girlfriend nor is it acceptable to kiss a prostitute.[12, 13] Secondly, homophobia has been outwardly expressed in the form of the often-repeated assumption that anal sex is not a Mozambican nor African practice, and is emblematic of the fear and disdain Africa has attributed to homosexuality (Anarfi and Antwi 1995; Bagnol 1996). To the contrary, ethnographies indicate that intra-thigh and anal sex has been practiced historically as play sex. In southern Mozambique, Junod (1962 [1912]) has documented this trend historically and Harrison (2001) in contemporary practice in South Africa.

Most young people facing early sexual initiation lack appropriate information, skills, and preparation to prevent pregnancy and STI/AIDS. The Mozambique DHS (1997b) establishes the average age of first sexual intercourse for women aged 20-24 at 16 years. This figure is higher for women of the same age in Maputo, who registered an average of 17.1 years for first intercourse. These data are similar to data collected in 1996, where the average age of first sex for girls was 16.6 years and 16.4 for men (Karlyn and Monjane 1998). The data are also comparable for most of sub-Saharan Africa, with the exception of such countries as Senegal where age at first sex among this youngest sexually active cohort is 19 years of age (UNAIDS 1999b). Between 1989 and 1995 age at first sex in Uganda for 15-19 year olds increased with girls who had never had sex increasing from 26% to 46% and 31% to 56% for boys. Young people aged 15 years who had not had sex increased from 20% to 50% (UNAIDS 1998).

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[12] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active .

[13] This citation convention to identify informants will be used throughout the thesis. The type of interview is represented by the acronyms FGD (focus group discussion) or SSI (individual semi structured interview) . The interview number and type is specified with 'T' indicating the source is the transcript of the tape, 'A' the annotated field notes, and 'S' the summary of the interview. Age refers to the age of the respondent or average age of all respondents if taken from a FGD. The symbol ♂ indicates male and ♀ indicates female participants. Mixed FGD are indicated by both symbols together ♂♀. Class indicates the highest class attained by the interviewee, or average attainment for the FGD. School attendance is represented as either in school or out of school. Sexual activity of the respondent is demarcated as either sexually active or inactive.

The number of years of sexual activity before marriage differs greatly by gender among young people in Maputo. Men averaged 6.1 years of sexual activity before marriage while women only 2.4 (Karlyn and Monjane 1998). In sub-Saharan African countries, 12% to 67% of young women experienced intercourse one or more years prior to their first union (Arnold and Blanc 1990), thus age at first union is not a strong indicator to capture all sexual exposure that leads to births prior to marriage. Moreover, the shift from arranged to romantic marriages places a greater value on intercourse and even fertility before marriage as a prerequisite (Gage-Brandon and Meekers 1993).

Pregnancy, contraception, abortion and infertility

Young people in Maputo, as elsewhere, seek sexual interactions for both physical and psycho-social gratification. Procreation may be a motive for some women, since early *prima-gravida* proves one's fecundity and thus worth in marriage. Similarly for men, having a child by one or more partners can be taken as a sign of virility and manliness.

About 23% of girls in Maputo are mothers or expecting a child by the time they reach 19 years old while the average age of having one's first child for women 20-49 years old in Maputo is 19.7 years (DHS 1997b). This figure is not surprising given that only one third of high-school girls in Maputo can correctly identify a woman's fertility cycle and indicate when she is in her most fertile period, rising only to 39% among over 18 year olds (Badiani, Zilhão, Bilale et al. 2000).

For girls, early pregnancy is a real threat to opportunities and ambitions as well as having significant social and economic ramifications. Among urban women throughout Mozambique, 9% left school early due to pregnancy. Among those school-leavers after primary school, pregnancy accounted for 25% of all female school-leavers (DHS 1997b).

Access to information about contraception in Maputo, similar to STIs and HIV/AIDS, depends greatly on autonomous factors such as education, wealth, class, mobility, and area of residence (Agadjanian 1995). These factors are accentuated by the social networks and resources women have at their disposal. Greater cohesiveness in social networks leads to improved information about modern contraceptives in Maputo (Agadjanian 1998a), as elsewhere (Valente, Poppe and Merritt 1996). In Maputo, knowledge of modern contraceptives is nearly universal (96% among women and 100% for men). Nevertheless, contraceptive prevalence is quite low among all women in union (28%), but high compared to the rest of the country (5%) (DHS 1997b).

Negative outcomes of unwanted pregnancy weigh heavily on young women in Mozambique. Abortion is considered 'quasi-legal' in Mozambique, whereby one law states that abortion is illegal unless the woman's health or life is at risk, a subsequent decree offers a wide interpretation of what constitutes risk to the woman (Agadjanian 1998b). Access to abortion, nevertheless, is limited by the reduced number of facilities, principally referral hospitals in provincial capitals which conduct the procedure. Negative outcomes are common, however, due to poor training of service providers and resulting complications (Granja, Machungo, Gomes et al. 2001; Gallo, Gebreselassie, Victorino et al. 2004; Jamisse, Songane, Libombo et al. 2004).

The burden of disease due to perinatal disorders, including sceptic abortion, is the leading cause of mortality in Maputo (Dgedge, Novoa, Macassa et al. 2001). An audit of maternal deaths from Maputo Central Hospital found that 75% of maternal deaths were avoidable, and caused principally by malaria, pre-eclampsia, puerperal sepsis, and septic abortion (Granja, Machungo, Gomes et al. 2001). Younger women are much more likely to seek a clandestine abortion than older cohorts, a trend associated with recent migrant status, lower economic status, unfamiliarity or non-use of modern contraceptive methods, and instability in partner relationship (Hardy, Bugalho, Faundes et al. 1997).

Potential positive outcomes of pregnancy – namely fulfilling one's desired family size, enhanced social status, economic support – cannot be denied in this context. Young women wrestle with the need to practice safer sex (condom or abstinence) and the desire to become pregnant (Varga 1997a; Preston-Whyte 1999). The decision whether to use a condom with one's permanent partner becomes clouded by the desire for greater intimacy and permanency in the relationship, coupled with a sense of invulnerability characteristic of young people, which makes the choice even more difficult (Gage 1998).

The inability to conceive, and the role of STIs in infertility, represents a significant threat to self-identity and social standing in Mozambican society as elsewhere (Dixon-Mueller 1991; Samucidine, Barreto, Lind et al. 1999). Once infertile, the desperation to conceive places the woman at even greater risk of STIs and HIV (Gerrits 1997). The cost of being childless has substantial social as well as emotional repercussions for women in Mozambican society. A pre-menopausal childless woman, regardless of her age, is considered a *menina* – literally young girl in Portuguese. Beyond the loss of status in society, a childless woman is barred from many traditional ceremonies. The economic consequences are significant as well, where intergenerational flows depend on the role of children to support their parents in old age. In

Mozambique, infertile women employ a myriad of help seeking strategies – marked by seeking other partners to maximise their fertility and encourage the same in their partners as a means of testing their virility (Gerrits 1997). In this context, a woman's identity is intricately tied to her reproductive potential that it raises important questions about the various femininities which exist in southern Mozambican society. Chapman (2003; 2004) demonstrates that the changing structural factors such as socio-economic conditions, health service delivery, kin relations, and social networks has led to a further reproductive vulnerability among Mozambican women. As social and economic pressure to bear children has increased, the social cost of infertility and infant mortality is heightened further (Chapman 2004). Much theorising has revolved around male identity and the multiple masculinities born out of homosexuality, deviance, and challenges to dominant models of sexuality (Connell 1996). By the same token, women in Mozambican society may find the hegemony ruling their reproductive lives equally repressive.

Sexually Transmitted Infections

No precise data exist on the prevalence of STIs among young people in Maputo, but ample evidence suggests that STIs are endemic and increasing among men and women in Mozambique (Liljestrand, Bergstrom, Nieuwenhuis et al. 1985; Vuylsteke, Bastos, Barreto et al. 1993b; Folgosa, Osman, Gonzalez et al. 1996; Bagnol 1998; Samucidine, Barreto, Lind et al. 1999; Osman, Challis, Folgosa et al. 2000; Castellsague, Menendez, Loscertales et al. 2001; Mbofana, Brito, Saifodine et al. 2002). About 12% of men nationally self-reported symptoms of an STI in the past year (PSI 2002). Likewise, HIV associated with tuberculosis is prevalent throughout the country, but especially so in the southern provinces (Mac-Arthur, Gloyd, Perdigao et al. 2001).

In a survey in a rural community close to Maputo (Manhiça), human papillomavirus was detected in over 55% of 14-20 year old women presenting at the public health clinic, indicated not only a risk for cervical cancer which was the objective of the study, but also unprotected sexual activity leading to exposure to HIV (Castellsague, Menendez, Loscertales et al. 2001). In a study undertaken in Inhambane Province in 1993, 15% of all clinic attendees had active syphilis and 4% of male patients were HIV positive (Vuylsteke, Bastos, Barreto et al. 1993a). Among blood donors in 1996 in Maputo, co-infection of syphilis and HIV were found to be 6% and 10% respectively (Tattevin, Renault, Joly et al. 2002). Among displaced pregnant women in rural northern Mozambique in 1994, 12% tested positive for syphilis and 3% for HIV (Cossa, Gloyd, Vaz et al. 1994). Among male prisoners in Maputo in 1993, 8% tested positive for syphilis and less than 1% for HIV (Vaz, Gloyd, Folgosa et al. 1995).

Programmatic efforts to improve the delivery of STI care for young people as well as STI patients as a whole has met with considerable success (World Bank 2000b). Nevertheless, the lack of effective roll-out and integration of prevention, care, and support interventions leave many vulnerable to STIs and HIV. While Mozambique exhibited a long-standing support and adoption of syndromic management of STIs (Cliff, Walt and Nhatave 2004), however Mbofana, Brito, Saifodine et. al. (2002) demonstrate the limitations of STI case management at the service delivery level. Numerous interventions were mounted to inform high-risk groups of the dangers of HIV/AIDS and STIs including traditional medical practitioners, prisoners, high school students, commercial sex workers, and military recruits (Santos and Arthur 1991; 1993b; 1993a; Green 1994; Green, Zokwe, Dupree et al. 1995; Vaz, Gloyd, Folgosa et al. 1995; Green 1996; Liquela 1996; Vaz, Gloyd and Trindade 1996; Green 1997; Machel 2001; Newman 2001; Mondlane 2002; Noya, I.A. Nhatave, H. Tojais et al. 2002; De Hulsters, Barreto, Bastos et al. 2003).

Pressure and coercion

Sexual pressure and coercion is an important source of concern for young women throughout sub-Saharan Africa (Heise 1993; Heise, Moore and Toubia 1995; Garcia-Moreno and Watts 2000; Maman, Campbell, Sweat et al. 2000; UNFPA 2000). In Maputo, rape was defined by study participants as male to female sexual penetration and the use of force, especially by someone older or a stranger, and without the woman's consent. Sexual pressure is everything up to the point of using physical force – coercion, physical threat, peer pressure, and emotional blackmail. By objective standards most of what is characterised as sexual pressure in Maputo would be defined as rape in any other context.[14]

Most young men and some young women in the study reported that a certain amount of coercion was necessary and justified. In neighbouring South Africa, male dominance and female submission is socially reinforced by gender power differentials (Varga 1997b; Varga 1999) and young people have adopted an adaptive view of sexual violence as acceptable (Andersson, Ho-Foster, Matthis et al. 2004). Interestingly, Andersson, Ho-Foster, Matthis et. al. (2004:952), found that the word 'rape' had to be substituted with 'forced sex without consent' because several of the indigenous languages found in South Africa did not have an equivalent term.

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[14] See Day (1994).

Coerced sex at first intercourse is associated with unwanted pregnancy, STIs, and likelihood of using condoms in the future (Koenig, Zablotska, Lutalo et al. 2004). Early marriage is also associated with higher risk of HIV/AIDS among young women due to a combination of factors including increased coital frequency, decreased condom use, inability to abstain, and having sex with a husband three times more likely to be HIV positive than an equivalent boyfriend (Clark 2004). Finally, victims of sexual violence are more likely to become infected with HIV (Dunkle, Jewkes, Brown et al. 2004).

For young people in Maputo consensual submission on the part of the woman is tempered by strong sanctions against ceding too quickly or showing sexual desire. To delay ceding is one of the strategies used by women to hold onto a man. Under these circumstances, a woman will say no when she wants to say yes, and it is seen as the responsibility of her partner to pressure her to know if no means yes or if no means no. Moreover, the context often decides how the situation will evolve. For example, if a woman is in the bedroom of the man it is implicit that she is not going to leave the room without having sex. Sanctions apply also to men. If a man does not pressure a woman into having sex, she will tell her friends that he did not pressure enough. His reputation will become stained and he will be perceived as being weak.

### *2.1.3 HIV/AIDS in Mozambique*

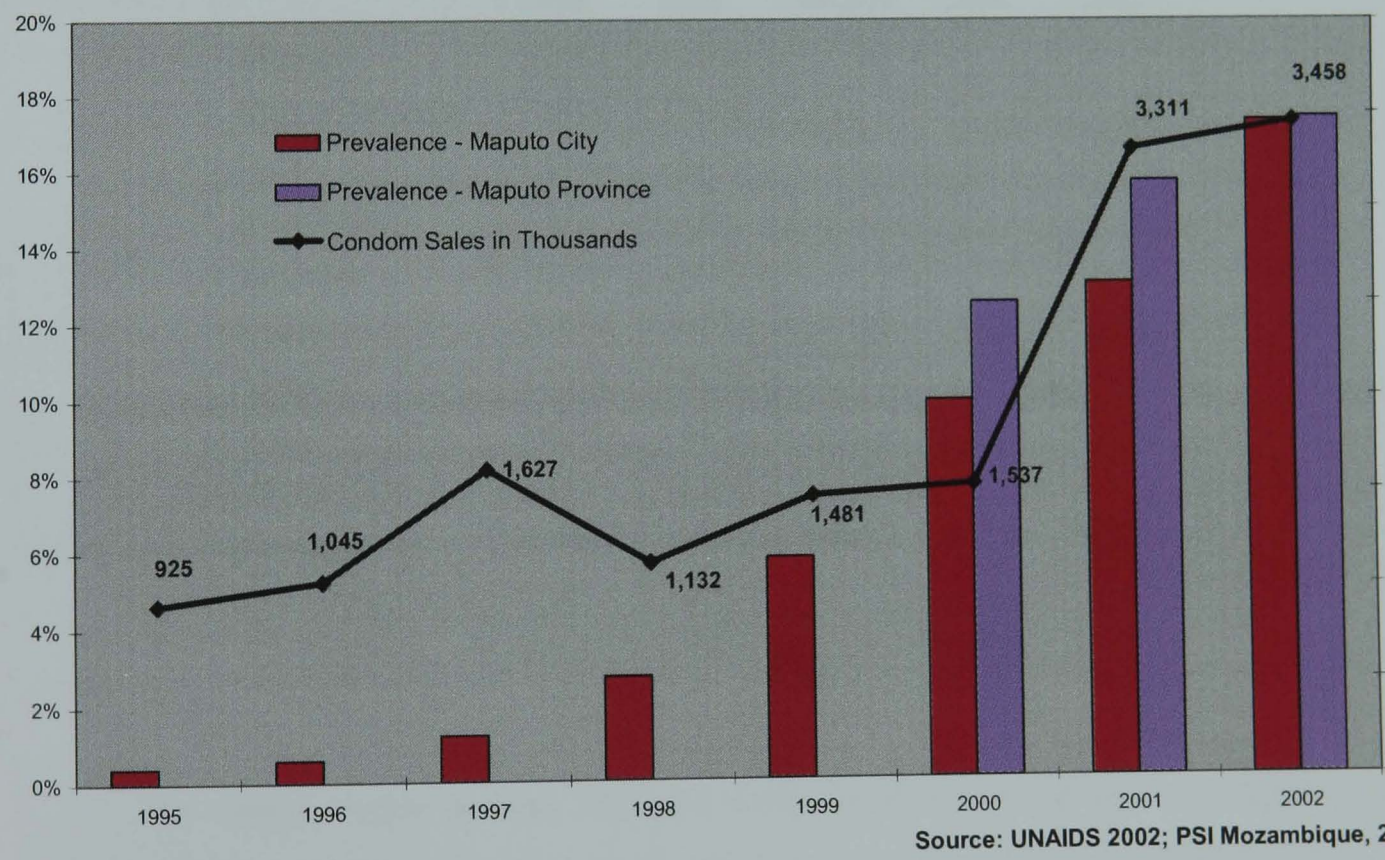
As demonstrated in the preceding two sections of this chapter, the conditions for the rapid spread of the HIV/AIDS epidemic were found in Mozambique. It is not surprising then, that Mozambique, and Maputo in particular, has seen a rapid rise in the rates of HIV and AIDS over the past 15 years. While only recent data are available on the state of the epidemic in Mozambique, the most up-to-date surveillance data available estimates that 14% of sexually active adults aged 15 to 49 in Mozambique are HIV positive as of 2002 (MoH 2003). This average however, masks the wide variations found across geographic zones, with urban areas and those laying on transport corridors or contiguous with neighbouring countries with even higher prevalence rates (MISAU 1998). In part, improved transport linkages as well as the historical dislocation of war refuges from Mozambique into neighbouring countries contribute to this trend. Districts with high numbers of returnees have a similarly high HIV seroprevalence rates, a correlation that has been proven to be statistically significant (Barreto, Foreit, Noya et al. 2002; De Hulsters, Barreto, Bastos et al. 2003).

In Maputo, 17% of sexually active adults are HIV positive. The highest rates were found in Sofala province where 27% are infected. These data, like all surveillance data coming

from antenatal clinics, are subject to potential bias and should be interpreted as such (Zaba, Boerma and White 2000). Most importantly however, they show a trend of a worsening epidemic. In Maputo, the surveillance data shows an increase in seroprevalence from 10% in 1998 to the 17% cited above (UNAIDS 2002b).

More women are infected than men, with women comprising about 60% of all infected adults in Mozambique (MoH 2001). HIV prevalence among women 15 to 24 years old ranges from 11% to 19% while the rate among men is 4% to 7%. It should be noted the vast majority of sentinel surveillance facilities are located in urban areas (UNAIDS 2002a). Furthermore, most Mozambicans are unaware of their HIV status due in part to the poor health infrastructure as well as fear of stigmatisation. Even with improvements in data collection in Mozambique, very little continues to be known about specific risk behaviours across segments of the population.

***Graphic 2: HIV Prevalence: Maputo ANC surveillance (1998-2002) compared with condom sales (1994-2002)***




**Source: UNAIDS 2002; PSI Mozambique, 2003**

Maputo's rapid rise in seroprevalence during the late 1990's and early 2000 has had an important impact on perceptions of the epidemic. Up to that point, the HIV/AIDS epidemic had been a distant issue and removed from the consciousness of most of Maputo dwellers. Prevalence rates in Maputo rose dramatically and the public face of the disease, as evidenced by the prominence of the people living with AIDS (PLWA) organisation Kindlimuka, could not be ignored. Condom sales by PSI reflected this trend, albeit with some lag. Between 1998 and

2001, condom sales trebled in Maputo and Province (PSI 2003). To be sure, there was some leakage to other provinces in the South. However project reports indicate that few large, one-off distributions were made over this period. Rather, the rise in condom sales is indicative of an increase in demand for condoms

Significant regional differences in levels of HIV infection are evident in Mozambique (see Table 1 below). As elsewhere in sub-Saharan Africa, the rates of HIV-infections are higher in urban areas than in rural areas, and are also higher near main transportation corridors, especially those connecting central Mozambique with Zimbabwe and southern Mozambique with South Africa (FDC 2001; MoH 2001). Recent assessments also point to a rapid rise of seroprevalence in the south (FDC 2001), which may be due to the combination of vigorous economic growth, fuelled by the region's proximity to South Africa, and the relatively low levels of condom use (Foreit 1999; Agha, Karlyn and Meekers 2001).

***Table 1: Adjusted HIV prevalence rates***

| | **2000** | **2002** | **Region** | **2000** | **2002** |
|---|---|---|---|---|---|
| Maputo | 13.5% | 17.3% | South | 12.0% | 14.8% |
| Maputo Province | 14.4% | 17.4% | | | |
| Gaza | 12.6% | 16.4% | | | |
| Inhambane | 7.8% | 8.6% | | | |
| Zambézia | 10.0% | 12.5% | Centre | 14.4% | 16.7% |
| Sofala | 20.6% | 26.5% | | | |
| Manica | 17.3% | 19.0% | | | |
| Tete | 16.3% | 14.2% | | | |
| Niassa | 6.2% | 11.1% | North | 5.7% | 8.4% |
| Nampula | 4.8% | 8.1% | | | |
| Cabo Delgado | 7.5% | 7.5% | | | |
| NB: 2000 rates adjusted based on 2002 data, Source: (MoH 2003) | | | | | |

The central region borders high prevalence countries of Zimbabwe, Zambia, and Malawi and correspondingly has the highest infection rates in Mozambique (see Graphic 3 next page). The southern region, bordering South Africa and Swaziland, has the second highest rate and has seen dramatic increases over the past several years. Regional differences have been noted in several studies (Barreto, Foreit, Noya et al. 2002; Liotta and et al 2002; Noya, I.A. Nhatave, H. Tojais et al. 2002), while other studies indicate pockets of attenuated HIV prevalence in risk groups such as prisoners (Vaz, Gloyd and Trindade 1996), army recruits (Newman 2001), and tuberculosis patients (Mac-Arthur, Gloyd, Perdigao et al. 2001).

*Graphic 3: Mozambique Map*


Source: United Nations (2004)

The national response to the AIDS epidemic

From 1995 to the period leading up to the fieldwork in 2000, comprehensive HIV/AIDS prevention in Mozambique was limited to a few actors. In part, this was because of delays in both the donor community and the GRM in recognising the impending epidemic to come, especially after coming out of a long and exhausting civil war. AIDS was seen as an external threat, and one propagated by foreigners and homosexuals.[15] Moreover, the GRM took a decidedly pronatalist view toward population policy. In part, this reflected the high economic and social value placed on children and the perceived need to make up for the population growth lost during the war (Agadjanian 1998b). While not directly conflicting with

[15] AIDS was associated with homosexuality, and since sex between men did not happen among Africans, AIDS was not an African problem (Epprecht 1998).

AIDS control policies, the pronatalism on the part of the GRM did delay developing more comprehensive reproductive health interventions. As a result, support for reproductive health was directed toward bilateral support for GRM health facilities and STI syndromic management (Mbofana, Brito, Saifodine et al. 2002; De Hulsters, Barreto, Bastos et al. 2003). Other clinical activities sponsored by the GRM included support for an AIDS day hospital outpatient facility at Maputo Central Hospital.

Prevention efforts by the GRM have intensified in recent years. Under the auspices of the Cabinet of Ministers, an inter-sectoral National AIDS Council was established to coordinate the national response to HIV/AIDS (Mondlane 2002). A National Strategic Plan to Combat STI/HIV/AIDS was adopted and publicised in the local media (MoH 1998; 2000). The National Strategic Plan calls for the following foci: 1. Implementation of essential activities to prevent HIV infection, directed toward young people, particularly girls, highly mobile individuals, and sex workers; 2. Implementation of essential activities to reduce the impact of HIV/AIDS, aimed at orphans and people living with HIV/AIDS; 3. Improvement of the quality and coverage of programs in youth-to-youth education, STI diagnosis and treatment, voluntary counselling and testing, and treatment of opportunistic infections; and 4. Implementation of HIV/AIDS activities in the northern, central and southern corridors (MoH 2004). In addition, a number of studies and interventions have focused on selected groups such as pregnant women (Barreto, Liljestrand, Palha de Sousa et al. 1993), the military (Newman 2001), workers of small and medium-size enterprises (Barradas, J. Donato and H. Madore 2002), truck drivers (Mohamed and Pacca 2002a), youth and young adults (Mohamed and Pacca 2002b; Morris, Mazive, Prata et al. 2002), on selected areas (Sherr, Jacqueta, Gimbel-Sherr et al. 2002), or on urban population in general (Karlyn and Monjane 1998).

New awareness-raising initiatives have been deployed to slow the spread of the epidemic, such as the Kulhuvuka - Corridor of Hope project funded by USAID. These efforts mirror similar interventions in neighbouring countries and focussed on a series of interventions along the Maputo Corridor which stretches from the border with South Africa to Maputo and then north along the main highway to Gaza and Inhambane provinces (Wilson 2000; FDC 2001). Efforts of this type are hampered by the lack of group cohesion, resources and strong stigma and prejudice surrounding HIV/AIDS (Sherr, Jacqueta, Gimbel-Sherr et al. 2002). Despite the media campaigns, public misconceptions and stigma about HIV/AIDS persists (Barradas, J. Donato and H. Madore 2002). Even in urban areas where information and prevention programmes are the strongest, HIV/AIDS remains an abstract threat and behaviour

change slow to take place (Agadjanian 2002a; Barradas, J. Donato and H. Madore 2002). As a result, Mozambique's HIV/AIDS levels are expected to rise, at least through the end of the decade (MoH 2001).

By 2000 there were roughly 55 national and international entities registered with the Ministry of Health working in HIV/AIDS prevention and support (GRM 2001). National NGOs and member organisations make up the largest group of entities in the field, with 16 organisations registered. Many are membership organisations such as the Association of Secondary School Teachers or the National Organisation of Women (OMM), the latter of which is typical of parastatal/party apparatus that has subsequently spun-off from direct state control. The local AIDS service organisation MONASO is an example of a quasi-NGO established specifically for HIV/AIDS prevention by the GRM. Other more independent NGOs and community-based organisations include AMODEFA which is the Mozambican IPPF affiliate, the Red Cross (CVM), and Kindlimuka – the only organisation of PLWA existent at the time. Only one, ARO Juvenil, had the specific remit of working with young people. The second most common entity working in the sector was line ministries within the GRM. Fourteen government units were identified as responsible for HIV/AIDS activities in their sector but not all had ongoing activities (Mondlane 2002).[16]

The donor field was also crowded with 14 donors reporting continuing activities in the sector. This number is deceptive as the field was dominated by several large bilateral and multilateral donors. There were 10 international NGOs registered with the GRM, although there were many others not registered with the MoH at the time. The largest HIV/AIDS programme at the time belonged to PSI which implemented the national condom social marketing (CSM) programme. Other prominent interventions include Action Aid's Stepping Stones programme which was novel in its approach but limited in scale. In recognition of the global paradigm shift associated with the Cairo ICDP conference in 1990, a gradual shift in GRM policy took effect post 1996 which favoured the broadening of sexual health interventions to include family planning initiatives as well as comprehensive adolescent sexual health interventions. UNFPA/Pathfinder's *Geração Biz* (New Generation) youth project and youth friendly health clinics are examples of this policy shift (World Bank 2000b).

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[16] These data pre-date the formation of an intersectoral National AIDS Commission, formed by decree No. 10/2000 23 May, 2000, Counsel of Ministers, Bulletin of the Republic I, Serie 21.

## Condom social marketing (CSM) and the discourse of prevention in Mozambique

The remainder of this chapter focuses on the *Jeito* CSM Project, certainly the largest AIDS prevention activity in size and scope in Mozambique during the period of 1994 to 2000. The Project became emblematic of the GRM's approach to AIDS prevention and effectively dominated the NGO scene by sheer size and geographic spread. The Project's approach came to influence the prevention discourse in important ways. It promulgated a prevention discourse focused mainly on individual determinants of risk, in an overtly epidemiological model of transmission. The social and contextual factors driving risk practices were incorporated into a generic approach of cultural sensitivity such that interpersonal communication channels were used to couch what was effectively an external prevention discourse into the language and performance of Mozambican culture. For these reasons, as well as my personal involvement and knowledge of the Project prior to the conduct of the study, I continually return to the Project throughout the thesis as an example of how. interventions address the needs of young people they purport to serve.

The *Jeito* Project began in 1994 in four pilot provinces and expanded to the national level in 1997. Before PSI's arrival, condoms were distributed free in a limited number of public sector outlets. Through initial formative research, PSI developed a locally appropriate brand and communication strategy while expanding a national distribution network through commercial private sector partners. Behaviour change communications were directed toward groups considered at higher risk of acquiring HIV through both interpersonal and mass media channels. In each of Mozambique's ten provinces, PSI staff co-ordinated communication and distribution activities. The provincial agents supervised teams of 4-8 community-based agents who carried out most of PSI's interpersonal communications (IPC) activities at the district level and below. In the first six years of the Project from 1995 to 2000, over 42 million condoms were sold (PSI 2002). Brand identity and awareness reached nearly universal levels and the name *Jeito* became synonymous with condoms (Davis 1997).

*Jeito* condoms are marketed and promoted in Mozambique principally to prevent HIV/AIDS and STIs, as well as a form of contraception. The branding strategy projects a youth-oriented brand espousing a positive lifestyle choice. The brand name *Jeito* is arguably the most important asset of the Project. The word means ability, style, or flair in Portuguese. Project advertising exploits the brand name's powerful double meanings through brand slogans, music, and theatre. PSI's network of provincial and community agents direct IPC activities

toward specific high-risk groups and distribute condoms to outlets associated with these groups. This targeting strategy is self-selecting but does not necessarily guarantee equity (Price 2001).

Instead PSI follows an assisted distribution strategy which lowers the price of the condom significantly through subsidy. This approach fits well with the MoH strategy of income targeting through geographic exemptions rather than means testing. At the inception of the Project an agreement with the MoH was made to distribute condoms for sale only in urban areas and along major transport corridors. At the same time, the MoH would distribute free, unbranded condoms to rural areas and to specific groups viewed unable to afford socially marketed condoms. In effect, this created a two-tiered system whereby rural populations with limited purchasing power had less access to condoms because of the inevitable failure of the MoH to consistently supply free condoms in remote areas. To a certain degree, PSI assisted the distribution of free condoms to rural areas on an *ad hoc* basis.

The *Jeito* Project aggressively scaled-up IPC to a national level. Behaviour change activities targeted young people and high-risk groups, including commercial sex workers, nightclub patrons, truckers, the police/military, and STD clinic attendees. The communications strategy included the *fogo cruzado* peer education debate, theatre, and mass media promotion. Community-based theatre was used extensively, with four commissioned plays and sketches containing safe sex messages directed at specific target groups. The Project created a network of 80 community-based agents and 10 theatre groups to carry out communications and distribution activities. In 1998, an average of 1,300 individuals participated in IPC activities including the *fogo cruzado* and theatre performances. By the end of 1998, almost one million individuals participated in the Project's interpersonal communications activities. During this period, the Project invested heavily in training and materials development for both interpersonal and mass media communications, requiring 6 to 12 months from the initiation of activities in each province to reach satisfactory operational capacity. Mass media advertising, especially through radio, was positioned specifically to complement behaviour change activities at the individual level. Radio spots were aired thousands of times in 10 local languages as well as Portuguese to promote safer sex and the use of *Jeito* condoms. Other media used by the Project include print, outdoor advertising, and television (Davis 1997; Karlyn and Monjane 1998).

The *Jeito* Project typifies an individual, deterministic model of behaviour change. The Project is based on a set of preconceptions largely accepted by NGO, donor and government sectors. These include but are not limited to:

- Condoms are a necessary and essential element to prevent the transmission of HIV/AIDS.
- Condoms are a commodity which should be sold to guarantee that they are used and distributed through private sector commercial entities which presumably have a greater reach to the population at large.
- Social communications, interpersonal as well as mass-media, are the most efficient and effective means to reach individuals with behaviour change messages.
- Individuals will heed the warnings provided to them through social communications campaigns.
- Branding is a powerful tool which can affect the perceptions of individuals towards a product, thus creating greater demand for its use.

These preconceptions have contributed to the discourse on how to affect behaviour change in Mozambique, and the standards by which interventions are measured (Pfeiffer 2004). For instance, the *fogo cruzado* was used as the basis for the development of the national manual for peer education to prevent HIV/AIDS (MoH 1997). However, the intervention methodology has had no independent validation or assessment to facilitate its diffusion to other institutional contexts. The prevention discourse also diverted money away from other interventions at a critical stage in the investment of prevention, care and treatment modes.

Unfortunately, we cannot know what the effect of alternative interventions would have been in Mozambique; however, we can examine the impact of the *Jeito* Project and similar interventions. To this end, Section 3.3.3 examines the implicit assumptions contained in individual oriented interventions with a view towards how future interventions may be improved.

Program impact and ARH in Mozambique

The impact of the *Jeito* campaign has been positive, although the methodology used in evaluating the Project cannot give a definitive measure of the impact compared to other adolescent reproductive health programs (Speizer, Magnani and Colvin 2003). In fact, most behaviour change interventions fail to meet adequate standards or rigour (Michie and Abraham 2004).

Overall, the findings indicate that the Project contributed to behaviour change in high-risk populations in Mozambique (Karlyn 1998a; Karlyn and Monjane 1998; World Bank 2000a; 2000b; Karlyn 2001). In an evaluation of the *Jeito* Intervention, a nationally representative survey of urban zones in Mozambique demonstrated that condom use in high-risk encounters was significantly higher in provinces with condom social marketing in place,

than those with little or no intervention (Karlyn and Monjane 1998). Furthermore, exposure to condom advertising and distribution when controlled for other factors is positively associated with safer sex behaviours (Agha, Karlyn and Meekers 1999).[17]

Programme exposure, however, does not explain differences in sexual behaviours across relationship types, time, and risk groups. High-risk behaviour continues despite high indices of preventive knowledge, high perceived severity of the epidemic, and access to preventive resources. Most urban Mozambicans know what a condom is (87%) and recognise condoms by brand (79%). Of those who have ever used or seen a condom, 77% know where to obtain them. Most (83%) perceive little difficulty in obtaining a condom if they wanted to. Furthermore, over 77% of urban Mozambicans can correctly cite condoms as an effective protection against HIV/AIDS transmission. Nevertheless, condom use is limited to only one-fourth of all high-risk sexual encounters (Karlyn and Monjane 1998).

The marked gap found between knowledge and behaviours can be attributed to factors beyond the scope of a traditional, quantitative survey, including group-specific perceptions of risk and attitudes associated with self-efficacy, coping strategies, inter-partner communications, and relationship systems. Based on existing evidence, behaviour change has yet to happen in Mozambique on a large-scale. The question of how to control the HIV/AIDS epidemic in Mozambique has reached crisis proportions, with all stakeholders looking urgently for answers.

However, some progress was achieved based on results of the PSI evaluations. Knowledge of two or more ways to avoid sexual transmission increased from 64% in 1996 to 68% in 2001. In 1996, 27% of respondents reported one or more non-regular partner, which reduced to 23% in 2001. The use of a condom with one's last non-regular partner increased from 23% in 1996 to 34% (PSI 2002). About one quarter (26%) of adolescent women (or their partners) used condoms and 23% of males used condoms in last intercourse (Morris, Mazive, Prata et al. 2002). Most salient here is the trend increase in condom use between (Morris, Mazive, Prata et al. 2002) and (PSI 2002). The 1997 DHS (1997b) found 2% and 7% condom use respectively, compared to 6.2 and 12 percent for women and men in 2004 . In school youth show slightly higher condom use rates, with about a third of young people having used condoms during sexual relations in the 6 month period before the survey (Badiani, Zilhão, Bilale et al. 2000). Nevertheless, the preferred method of reducing risk is to reduce the number

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[17] As research director for PSI prior to the conduct of this study, I conducted a number of program interventions designed to measure the behavioural impact of the activity. While the evaluations were conducted internally, the evaluation results were reviewed externally through peer publication.

of partners and to evaluate one's partner based on appearance (Futures Group 2001; Agadjanian 2002b).

Despite the high awareness, few considered themselves personally at risk of AIDS. Two thirds of men and more than half of all women surveyed perceived themselves to be at little or no risk of HIV/AIDS (Futures Group 2001). Furthermore, comparing self-reported risk and risk imputed from self-reported sexual behaviour shows a tremendous gap in self-assessment among young people in Mozambique, with only 53% of men and 47% of women able to correctly assess their risk (Prata, Morris, Stehr et al. 2003). This gap highlights the subjectivity of risk and the importance of social distance shaping risk perception. In part, this may reflect methodological issues, nevertheless it suggests the insularity used by individuals when in comes to HIV/AIDS.

## 2.2 Conclusion

In this chapter I have traced both the distal and proximate factors contributing to the rise of the HIV/AIDS epidemic in Maputo. I stress the relevance of distal factors, which are often underestimated or dismissed as irrelevant when designing and implementing behaviour change interventions. No doubt poverty, poor health status, social dislocation, and migration all contributed significantly to the rise of the AIDS epidemic in Mozambique. Proximate factors, likewise, stress the social and structural conditions which have resulted in the epidemic. While the facilitating relationship between STIs and HIV/AIDS is well established (Grosskurth, Mosha, Todd et al. 1995), the impact of poor sexual health services for young people is largely underestimated (Kane and Wellings 1999). Moreover, the chapter highlights the importance of gender power relations in determining sexual risk among young people in southern Mozambique, which has negative consequences for young women and partially explains their higher rates of HIV.

To understand the impact of HIV/AIDS in Mozambique, I have demonstrated how national and international NGOs have responded to the AIDS epidemic. The national response to the epidemic is indicative of popular conceptions of the severity of the epidemic, as well as the stigma associated with it. The delayed formation of an inter-sectoral National AIDS Commission in 2000 reflects an over-medicalisation of the epidemic by the GRM and society as a whole, and not as a pervasive threat to all sectors of society. While elements of Mozambican society called for a comprehensive response prior to 2000, it was only when the epidemic accelerated in Maputo did the elite of the city take notice. Furthermore, the choices

made by the GRM and donors in their approach to prevention up to 2000 shows the dominant discourse shaping perceptions of the epidemic. The chapter documents this trend through the presentation and analysis of the principal prevention activity in Mozambique from 1995 to 2000 – the *Jeito* Condom Social Marketing Project. The *Jeito* Project demonstrates how the prevention discourse was structured around individual-oriented, deterministic models of behaviour change. Despite the best efforts of the Project, as well as others, none has stemmed the rise of the epidemic in Maputo.

In the next chapter, I review the literature on behaviour change and attempt to identify why there is a persistent gap between knowledge of prevention practices and sexual behaviour. I continue with the example of the *Jeito* Project to demonstrate how models of behaviour change typical of such interventions contain biases that ultimately make such interventions less effective. Interventions often fail to account for the heterogeneity of young people as sexual agents which is apparent in the literature. Interventions lack a critical reflexivity of their inherent biases which in turn shape how they interact with their clients. I examine social marketing as a model of intervention to demonstrate how theory becomes practice in intended as well as unintended ways. Lastly, I propose alternative frameworks in which to examine the sexual health of young people from the perspective of an intervention with the objective of identifying tools for improving programme interventions.

## 3 ANALYTICAL FRAMEWORK OF RISK

To consider how risk works in shaping sexual practice, we must examine the social field that defines social and sexual interactions. The social field consists of practices, embodied and materially organised around shared practical understanding. Practices are thus the basic unit of social organisation and consist of individual and group actions originating from and regulated by the adherence to a set of rules (Schatzki 2000).

Practice theory has emerged as a unifying concept in social science theory, supplanting what was once thought to be the building blocks of social objects – structures, systems, events, and actions. Importantly, practice theory shows us how we come to do what we do. It helps us understand the rules that specify behaviour in particular contexts and the values ascribed to actions in the form of norms.

Why is practice and norm formation relevant to AIDS interventions? The actions comprised in sexual practice are driven by risk perceptions, sexual identity, and gender roles. Sexual practice is thus socially constructed, born of a specific context and encoded with the language, modes of communication, and rules of interaction relevant to that changing context. The power and significance of language as a mediator of practice highlights the role language plays in asserting hegemony of one interest over another (Foucault 1979). Human action and the interpretations of those actions thus create novel social reality. The social reality shared by young people in Maputo consists of behavioural scripts, sexual and otherwise, that shape individual action and in turn the norms guiding further practice. Society provides the reservoir of resources that individuals and groups may draw upon in forming practice. According to Ortner (1984) this pool is asymmetrical in that it may constrain action, at the same time respond to manipulation either through unconscious action or improvisation (Bourdieu 1977).

In functional terms, everyday practice in the form of action and agency reproduces social structure, while social structure in turn changes practice. This is distinct from the Durkheimian model of behaviour directed by social structure and cultural determinism. Instead, I suggest that rules guide behaviour while leaving sufficient space for the moral construction of social facts as part of the natural world. Improvisation in daily life allows individual actors the ability to employ rules and norms in strategic ways to alter practice. How we improvise is theorised as an unconscious process of learning to know how to do the right thing in a given situation, in other words, the made world of common sense. Bourdieu (1977) saw improvisation as a central feature of practice, situated in a specific context of time and space.

Bourdieu conceived of the habitus as an organising framework of cultural dispositions, both past and present, in the form of schemes of perception, thought and action (Bourdieu 1990). Practice is also intricately linked to our sense of self, social identity, and body. The body is a primary tool in improvisation. It is a commodity in which identity and power are vested. The self is experienced and expressed through investments in that identity (Foucault 1979). Sexual practice is one such embodiment, and through the social construction of sexuality we can examine the power relationships that define gender roles, sexual expression, and perceptions of risk.

While practice theory helps us to understand the underlying processes of social change at the individual and structural levels, it does not directly address the micro-processes contributing to sexual behaviour and risk assessment. To consider the question of how behaviour change happens, this chapter presents an analytical framework based on practice theory and elaborated as the social construction of risk and sexuality. Several behaviour change models will be considered, but organised around the example of the *Jeito* Project which has adapted several models to justify its intervention. These models are critiqued based on the evidence in the literature. In addition, examples of effective application of behaviour change are given. Finally, I present script theory as an alternative theoretical framework in which risk practices may be considered.

## 3.1 Social construction

Social construction is predicated on the notion that practice and the interpretations thereof create social reality. The multiple meanings of practice, as represented by actions, are not only based on an inherent set of rules governing social interaction. Social reality is constructed through common interpretations of the situation in which actors interact. Language, modes of communication, and rituals of interaction contribute to the construction of meaning, which allows action to proceed along a set of recognised rules and realities.

The application of social construction theory to the topic of sexuality and risk marks a significant shift in research on sexuality (Parker and Gagnon 1995b). Social construction has been used to explain other health outcomes based on such factors as the social interaction between doctor and patient, particularly along the lines of pain management and informed consent (Alderson 1998; Alderson and Goodey 1998). Bates (1995) demonstrated how two different cultural groups can experience chronic pain differently; the expression represents distinct realities to each. The conceptualisation of sexual practice as a social construction

recognises that societies and cultures engage in a process of social moulding whereby the basic biological components of sex are directed toward specific social ends. Both micro and macro structures, thus, engage in an active process of constructing what is appropriate sexual practice for individuals based on implicit and explicit sets of rules (Dowsett, Aggleton, Abega et al. 1998).

Studies of sexual behaviour have been criticised for lacking an understanding of sexuality, and the social pressures that cause people to behave as they do in sexual relationships (Holland, Ramazanoglu, Sharpe et al. 1994). Vance (1991) argues that the specious use of terminology about sex and sexuality has hindered the field of sexuality research. In particular, gender roles associated with distinct masculinities and femininities have largely been ignored (Barker 2000). Sexuality is a socially constructed phenomenon that cannot easily be reduced to predictive indicators (Vance 1991; Kippax, Crawford, Davis et al. 1993) and specific reproductive health outcomes (Dixon-Mueller 1993).

The treatment of young people as an homogenous group, particularly in quantitative approaches to sexual behaviour research, misses important distinctions in identity and behaviour among this diverse group. Historically, the categories of adolescent, youth, and young adult have been used to describe young people, yet these terms fail to clearly distinguish the period between childhood and adulthood. Such terms are bound by Western conceptions of a period of dependency on family, community, and society as individuals come to take on productive roles in society.[18] The distinction between the various physical and emotional stages of young adults has coincided with a more nuanced understanding of the contextual factors driving young people to take risks, including the perceptions of young people themselves in what risk means (Paiva, Ayres and França Jr. 2004). The inability to translate survey results into interventions is due, in part, to the lack of contextual information driven by young people themselves (Dowsett, Aggleton, Abega et al. 1998).

The general failure to isolate causative factors predisposing young people to take sexual risks has stimulated research into the contextual factors leading to risk practices, as well as the adoption of a more integrative theory of young people's sexuality. The use of exploratory, qualitative methods of inquiry has facilitated the documentation of contextual factors. For AIDS interventions to be more effective, they must incorporate young people's own

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[18] In this thesis, young people will be used as a generic term to include adolescents, youth, and young adults. The term adolescent will only be used to refer to the specific period of post pubescence, usually between the ages of 14 to 19.

perceptions of the risks they face in their everyday lives (Leclerc-Madlala 2002). The ambiguity and conflict that young people face reflect competing moral regimes in which sexual cultures are pluralistic, being neither traditional nor modern (Dilger 2003). In fact, sexual ideologies reflect larger social, political and economic realities that have evolved over time. While there has been a critical look at how sexuality has changed in post-colonial Africa (Caldwell, Caldwell and Quiggin 1989; Heald 1995), few studies account for the specific challenges faced by young people (Dilger 2003). Even then, the question remains whether interventions are in fact capable of: first, modelling normative patterns of sexual identities; and second, promoting normative identities in sufficiently meaningful and reflexive forms (Paiva, Ayres and França Jr. 2004). I contend that scaled-up interventions, such as the *Jeito* CSM Project, are unlikely to do so on both counts (Karlyn 2005).

### *3.1.1 Sex, sexuality, gender, and AIDS*

As a social construction, sexuality is situated in a cultural context. Historical factors determine the social significance and subjective meaning of sexuality. The approach makes a distinction between sexual acts, sexual identities, and sexual communities, while challenging universal gender roles and sexual meanings. The separation of gender roles and reproductive behaviour became apparent in research on the diffusion of contraceptive technology, studies of power in sexual discourse (Foucault 1981), and homosexuality (Weeks 1987). The inadequacy of traditional methods to understand and explain the relationship between sexual behaviour and STI/AIDS has forced researchers toward social construction theory to explain inter and intracultural variation in AIDS transmission (Parker and Easton 1998).

Lay understanding of sex and gender in Western societies often confounds the two. Sex is the biological designation while gender is a social construction of sexual identity. Sex is natural, irrefutable, and permanent. Exceptions to gender assignment are considered aberrant and pathological. Gender is mutable and interpreted. Individuals learn about gender roles from the earliest stages of social interaction, through parents, schooling, mass media, and everyday social contact. As a learned phenomenon, gender is constructed through the daily performances individuals enact to sustain or in some case refute their gender status. An individual can perform alternative gender roles by taking on the [physical or emotional] features of one gender or the other. The mutability of gender roles and sexual identity illustrates the relevance of social construction toward AIDS prevention. Several well documented examples exist of individuals who do not easily fit into the categories of male or female. Shepherd (1987) found an institutionalised third gender among East Asians living in Mombassa, Kenya, which is derived

from a similar group in Pakistan. Transvestites and *berdaches* (a Native American Indian gender role of a man adopting a female gender role or female adopting a male gender role) adopt a third category of sexual identity (Sweet 1996). Cross gender possession and homosexuality are found in Afro Caribbean religions with historic origins in Africa (Murray and Payne 1989). In Brazil, Parker (1992) found the erotic ideologies created alternative identities for sex between two members of the same gender, thus creating a third gender known as *bichas*. A *bicha* is a man who assumes, exclusively, a passive (receptive anal) sexual role which contrasts with the male gender role defined by active penetration of his partner without being characterised as homosexual. Given this variation in gender roles and identity, AIDS prevention programmes that target homosexuals as a distinct identity may miss individuals who do not consider themselves homosexual yet engage in male-to-male sexual intercourse.

Discourses of condom negotiation and risk also illustrate the utility of the social constructionist framework to inform prevention efforts. In a study of negotiation of safe sex among young heterosexual women, Holland, Ramazanoglu, Scott et al. (1991) examined the system of knowledge and meaning of social situations whereby condoms are used or rejected. Through an analysis of the symbolic significance of condoms in the context of gender power relations, the negotiation of condom use highlighted the contradictions and tensions in youth heterosexual relationships. Sexual relations in western societies are characterised by inequality, which makes condom use an outcome of negotiation between unequal partners. Since the meaning and language of sexuality reflect the gendered construction of sexuality, the sexual arena is the focal point for the struggle between competing discourses of sexual behaviour (Holland 1991).

Male dominance as sexual discourse affirms as natural the power inequalities between men and women and the myth that men have a biological need for multiple sexual partners. Likewise, female sexual discourses around condom use and STI/AIDS are dominated by themes of deviance (promiscuity), disease (pollution), and contamination (undeserving, dangerous) (Crawford, Lawless and Kippax 1997). The condom has become a symbol of mistrust within a relationship, rather than an expression of concern or caring for the health of oneself or one's partner (Taylor 1990; Longmore 1998). The gender roles and association of condoms with deviance create unequal terms of negotiation among partners. Male dominance is socially reinforced as is female submission, thus women are relatively powerless against male sexual coercion (Varga 1997b; Varga 1999).

### *3.1.2 Sexual risk*

The risk of contracting HIV through sexual contact is represented as the number of recent sexual partners and the non-use of condoms with these partners (Dare and Cleland 1994). This has led to the focus on key target or risk groups as core transmitters of HIV because their behaviours sustain continuing high levels of STIs within a community (Burnham 1991). Risk of contracting HIV through sexual means depends on the HIV status of one's partner(s), the correct and consistent use of male or female condoms, the stage of infection, and the presence of co-factors such as ulcerative STIs or male circumcision.

For many however, the number of partners and use of condoms does not adequately reflect risk. Rather, sexual risk is mediated by gender roles. Women generally do not control condom use by their male partner(s) (Dixon-Mueller 1993). Moreover, sexual networks play an important role in exposure to risk (Orubuloye 1994). Sexual risk is more than just a question of probability of infection. HIV/AIDS along with other STIs carry a range of physical as well as social implications much broader in scope than the narrow causal relationship used by epidemiology. The aetiology of HIV risk is inextricably linked to other reproductive health outcomes such as STIs, unplanned pregnancy, wanted and unwanted termination. It reaches into the realm of social and interpersonal relations. Women face the risk of abandonment or emotional/physical abuse if they insist on condom use or, if HIV-positive, disclose their status. In developed countries, assumptions as to who is at-risk along with the advances in treatment of HIV have altered perceptions of risk, leading to greater complacency and relapse in condom use (Dilley, Woods and McFarland 1997). Similar discourses are found in developing countries where, prominent dissenters, miracle cures and spiritual exorcisms such as the Mchape affair in Malawi (Probst 1999) create impediments to prevention efforts and obscure the potentially beneficial palliative and preventive role traditional medical practitioners play as predominant care-givers in sub-Saharan Africa (Green, Jurg and Dgedge 1993; Chalmers 1996; Masauso, Romano, Anyangwe et al. 1996). Moreover, sexual risk is a relative concept for a sex-worker who perceives her work environment as risky. Clients may become violent, condoms break, and economic insecurity make offers for more money to have sex without a condom seem less risky (Wojcicki and Malala 2001).

The objectification of risk is a defining feature of the AIDS epidemic throughout the world, and contributes greatly to beliefs and practices associated with stigma, prejudice, and ultimately to greater exposure to HIV and STIs. The labelling of certain sexual behaviours as high-risk and subsequent association with specific socio-demographic groups contributes to

stigma (Schoepf 1993). While the biomedical causality of HIV and AIDS is incontrovertible the definition of AIDS as a biomedical and social disease has varied greatly over its 30 year history. Nevertheless, a small group of AIDS dissidents, including President Mbeki of South Africa, has taken a denialist position on the causal link between HIV and AIDS (Lancet 2000).

Social and institutional biases have influenced the definition of AIDS and subsequently led to the categorisation of certain groups as at-risk by virtue of their social identity rather than purely epidemiological criteria. The association of HIV and AIDS with groups because of sexual orientation, intravenous drug use, race, and class all contribute to a social construction of those at-risk rather than those exposed to HIV. In a few cases, like that of Thailand's 100% condom programme among sex workers and their clients, the targeting of risk groups has proven to be effective (Rojanapithayakorn and Hanenberg 1996). In contrast, individuals not normally associated with a high risk group may be missed. Those associated with a risk group suffer greater discrimination regardless of their HIV status (Grove, Kelly and Liu 1997-1998). The same hidden biases are found within behaviour change interventions and result in the transformation of the human subjects of an intervention into risk objects. This greatly obscures the fact that they are vulnerable human beings in the process of negotiating risk and adopting new behaviours (Moatti, Hausser and Agrafiotis 1997).

The examples cited above demonstrate the relevance of social construction in understanding risk and HIV/AIDS. It further supports the need to document the context of risk to understand the process of risk mitigation. Context specific factors, both medical and non-medical, influence risk assessment and treatment options. Awareness of biomedical risks certainly does figure into individual risk assessment, but not necessarily in ways which lead to positive health outcomes. The consequences of acting or not acting upon risk have context specific meanings for individuals and thus form part of a highly subjective cost-benefit analysis (Wallman 2000). In the next section, I establish the link between risk and the context in which it is derived, culminating in a discussion of how risk of HIV/AIDS is conceptualised and ultimately put into practice in the form of prevention.

### *3.1.3 Risk and the construction of identities*

Up to this point, we have examined how risk is relative to a specific context, and that meaning ascribed to risk is derived from historical and social factors associated with class, power, gender, and ideology. The field of epidemiology is predicated upon the causal link between risk exposure and outcome. While epidemiology quantifies the unknown through measures of probability and approximation, it largely fails to explain the meaning of risk in

social terms. Critics argue the de-contextualisation of risk has led to an over-dependence upon uni-dimensional causation to explain risk outcomes, especially at the individual level, and contributing to a blame the victim mentality (Weiss 2001).[19] This is especially problematic for the prevention of chronic illness. Exclusion of the social and structural determinants of health behaviour obscures the meaning of illness and ultimately limits individual agency in health seeking. This strictly epidemiological approach tends to ignore the political economy of health that shapes our perception of illness and disease, and informs the theoretical basis of this study. In the context of this study, a political economy approach to HIV risk considers the structural factors contributing to risk exposure and associated with rapid social change, such as monetization of the economy, household composition, gender ideologies and roles, rural-urban migration, and health care delivery, and poverty (Farmer, Connors and Simmons 1996; Pfeiffer, Gloyd and Ramirez Li 2001).

Risk serves to mediate the ideal of what one should, could and actually does in a given situation. It gives meaning to actions and their repercussions. As an inherent component of practice, risk is expressed as apprehension, suspicion, and dread of the unknown. Giddens (1999) maintains that risk is inextricably linked with modernity and globalisation. Beck (1992) coins this the risk society whereby our social position largely determines our exposure to risks, and thus contributes greatly to our identity in the modern world. Bujra (2000) questions the appropriateness of Beck's and Giddens' writings on risk to the question of HIV/AIDS in Africa, principally on the grounds that their theory is Western focused and marginally applicable to the African context. She contends that Africa can hardly be considered entering a phase of late modernity. However, I contend that urban youth do in fact suffer the same kinds of class and economic alienation at the source of Beck and Giddens' writings. Class position situates the individual on a risk continuum relative to one's social group, and it is this relative position that largely determines individual susceptibility to risks as well as access to mitigating resources (knowledge, personal experience, and social capital). The accumulation of wealth is accompanied by the social production of risks, but wealth and risk are accrued disproportionately by different members of society. Witchcraft accusations are often associated with unexplained wealth acquisition in much of Africa as elsewhere (Bowen 2000). Such accusations have been ascribed to jealousy, but also reflect a predominant African ideology that wealth is a zero-sum game whereby one can only gain at the expense of others. Rather than an

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[19] As the neo-Durkheimians point out, there must be someone to blame. See also Kendall (1995), Inhorn & Whittle (2001), and Weiss (2001) for an overview of the debate on the future of epidemiology.

explanation of the unknown, risk is a by-product of progress. As such, social identities have formed around these accepted consequences of progress in the form of globalisation the winners extol the virtues of free trade through the institutionalisation of trade regimes such as the WTO; while the losers stage often violent protests of the inequitable terms of trade and lack of protection against usurious corporate and government entities seen to be accountable to none (Beck 1992).

How risk comes to define who we are and our place in the world is a central question in the formation of social identities. Giddens' (1991:244) concept of reflexivity demonstrates how individuals come to construct a self identity through "the reflexive ordering of life narratives". Sexual identities are an important and powerful form of self definition and expression marked by contestation, resistance, challenge and potentialities for change. The mutability of sexual identity refutes the naturalist argument for the constancy of heterosexuality (Foucault 1979). The purpose of mapping sexual identities is not about revealing some truth, but uncovering values which comprise identities, that distinguish one group from another, the relationships between them, and how they define inclusion/exclusion (Weeks 1995). It is important to note that life narratives may well be fictional, such that our interest is in how individuals construct their sense of self. Weeks (1995:44) comments the often fictional nature of sexual narratives is necessary to maintain a critical view of sexuality, revealing the "coils of power" revolving it. It also makes human agency possible and essential.

Blame serves to circumscribe and insulate the individual and group from risk. The disassociation of AIDS from illness, especially at early stages in the epidemic when knowledge of the disease preceded the actual appearance of individuals with AIDS, contributed to this social insulation. The blaming of others, such as homosexuals, foreigners, or those who have morally transgressed all contribute to multiple discourses of blame which creates confusion and ambiguity among individuals and communities at large. This ambivalence is reflected in rumours which constantly encircle the AIDS epidemic, undermining the veracity of biomedical definitions of AIDS and its causes. At the same time gossip serves to explain these ambiguities and apportion blame by creating moral categories assigned to specific actions and people. Both rumour and gossip create a social discourse around AIDS that explains how and why the disease strikes an individual, clan or community. Rumour and gossip demonstrate the social construction of the epidemic based on discourses of tradition, gender ideologies, class, and intergenerational relationships. Response to the epidemic, both at the individual and societal levels, is derived largely from these discourses (Stadler 2003).

As a moral discourse, risk offers considerable flexibility in interpretation rather than an absolute dichotomy of good/bad. The neo-Durkheimian school suggests that social context (mediated by institutions) defines the moral transgression that labels a risk good or bad (Douglas and Wildavsky 1980). The mutability of risk assessment varies greatly depending on the type of risk, the institutions that promote or mediate such risks, and the immediacy of risk outcomes. Frequent exposure to risk, such as driving a car or crossing a busy road, can diminish one's risk perception yet air travel seems much riskier. In some cases, risk is desirable and sought out. The eroticisation of risk can be a powerful motivational force (Kendall 1995). Risk seeking may revert to equilibrium evidenced by the compensatory actions of seat-belt wearers. As seat belt use increases, drivers tended to go faster in compensation (Richens, Imrie and Copas 2000).

Evans-Pritchard famously addressed the question of causation in explaining how and why the granary fell and killed the person underneath (Evans-Pritchard 1976 [1937]). The immediate cause was termites that ate away the support pole, but the real issue was why did it happen then and fall on that specific person? Often these explanations are syncretic or pluralistic. Biomedical definitions become integrated into local models of illness as immediate causes, following the same logic of causation. In the same vein, cultural beliefs and practices such as sexual cleansing and levirate marriage have been cast as obstacles to health promotion (Malungo 2001). In many cases the ability to explain why illness occurs rather than just how can provide important pathways toward prevention efforts and satisfy individuals and societies that seek explanations (Gausset 2001). A similar argument is put forth to explain youth sexual risk taking as a cultural phenomenon. A balance must be struck between the various factors contributing to young people's sexual practice. Youth sexual practice is certainly influenced by biological as well as individual volitional factors. At the same time, the framing of youth sexuality as purely structural, social, and cultural effectively deprives young people of agency. Nevertheless, structural factors play an important role in risk exposure, including: female sexual submissiveness, male dominance, sexual violence, survival sex, and intergenerational sex driven by older men seeking younger, uninfected women who, in turn, seek the social and economic advantages of having a wealthier partner (Zabin and Kiragu 1998).

Up to this point in the chapter we have established practice as the central feature of human interaction, and showed how the sexual practice in particular is socially constructed. Likewise, risk has been cast in terms of context and the structural factors which mediate risk

practices. Next we will consider how interventions have incorporated risk into behaviour change models, looking specifically at the *Jeito* Project as an example.

## 3.2 From theory to practice: The *Jeito* behaviour change model

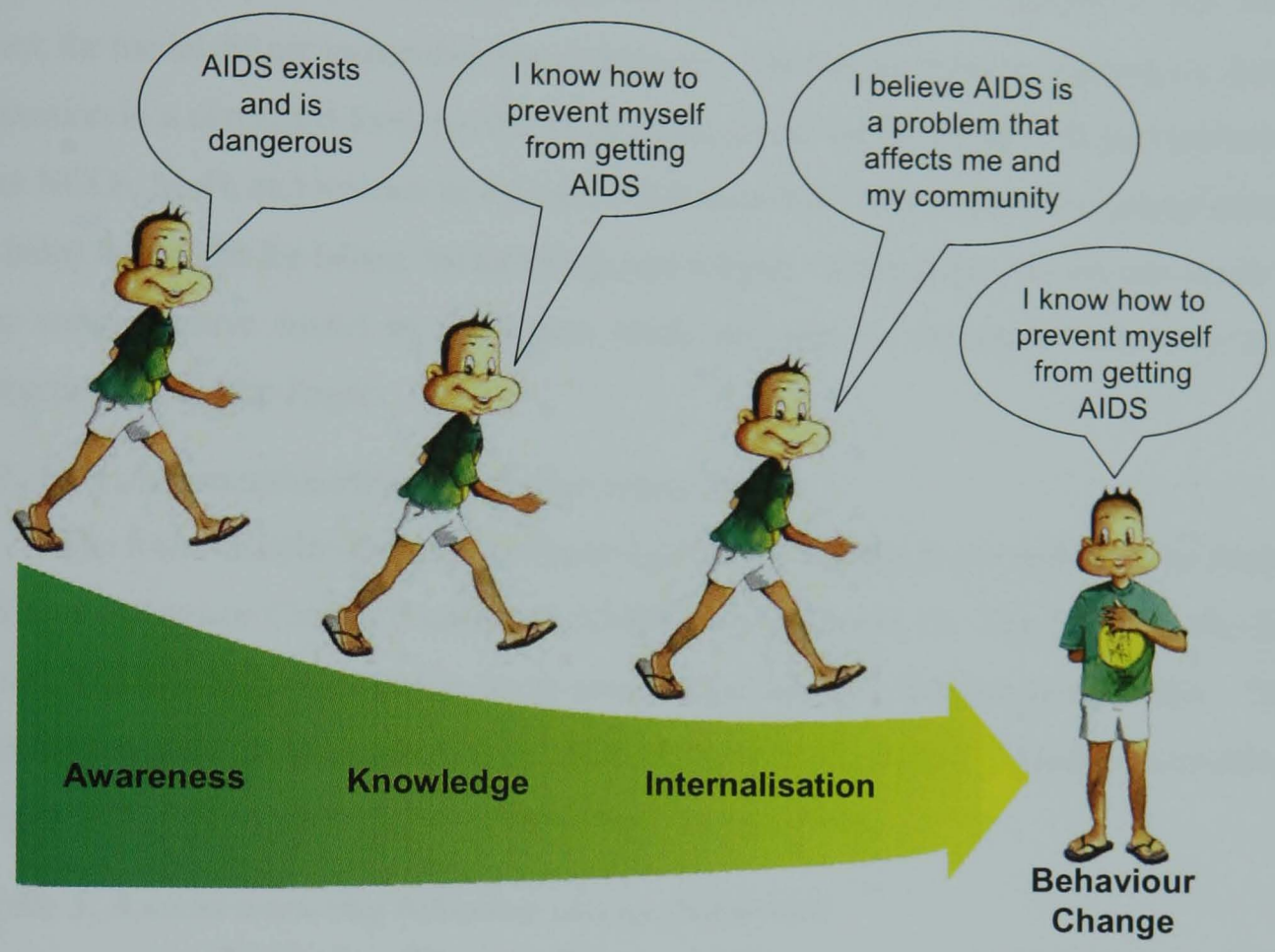
Practice theory has shown us how we come to do what we do, and in the process, explains how meaning (in the form of morality and risk) becomes attached to practice. Here I apply practice theory to specific behaviour change interventions to demonstrate how meaning is ascribed to such interventions and the actions they promote. All AIDS prevention interventions implicitly or explicitly incorporate one or more model of behaviour change into their design. Likewise, most models of behaviour change focus on the individual and share a common set of features and constructs in trying to reduce risk behaviours. At the same time, few interventions have effectively accommodated the social and cultural contexts which place certain groups at greater risk than others.

In this section, I review several of the most important behaviour change models to highlight how they reflect the evolution of the field, and specifically how they have guided interventions for HIV/AIDS prevention. I focus specifically at the intervention level to demonstrate how theory becomes practice. While research activities incorporate intervention components, they isolate effects and ignore many of the real world factors that confound interventions on the ground. Behaviour change interventions have the advantage of applying models without the constraints imposed by research interventions attempting to assign cause to one or more component of a model. I limit the discussion to change models employed by the *Jeito* Project for two reasons: first, the Project adopted an individual-focused model of behaviour change which had both intended and unintended consequences; and second, to provide an example of how behaviour change models are translated into practice.

### *3.2.1 Jeitoso's pathway to change*

The *Jeito* Project applied change theories consistent with the goal of broad-based social change. Since the start of the Project in 1995, the need to articulate a change model became apparent to senior management. In part, this was to satisfy internal demands to bring staff together around a common intervention ideology, but also for external consumption as public relations for key stakeholders and partners to understand the social marketing approach employed by the Project. The model, dubbed '*Jeitoso's* Pathway to Change', depicts "*Jeitoso*, the cartoon character used by the Project in its youth-oriented communications, walking the path to change in a linear, staged progression (Graphic 4) (PSI Mozambique 1997).

*Graphic 4: Jeitoso's pathway to change*




Source: PSI Mozambique (1997)

Unknown to the *Jeito* Project staff at the time (including this author), the Pathway describes the Stage of Change Model (also known as the Transtheoretical Model because it is an amalgam of several behaviour change theories) which lays out the stages one progresses through in adopting behaviour change (Prochaska and Di Clemente 1983; Prochaska and Velicer 1997). The model was first applied to the drug and alcohol abuse sector, but has since been applied to several health promotion problems including promoting healthy lifestyles through diet, smoking cessation, and exercise. The model depicts a continuous and linear process of stages from pre-contemplation, contemplation, decision, active change and maintenance. The model combines several theoretical approaches taken from psychotherapy and behaviour change theories and linked to key intervention points called stages. This allows the change agent to target the intervention toward specific leverage points leading to the change in individual behaviour (Chilvers, Harrison, Sipos et al. 2002).

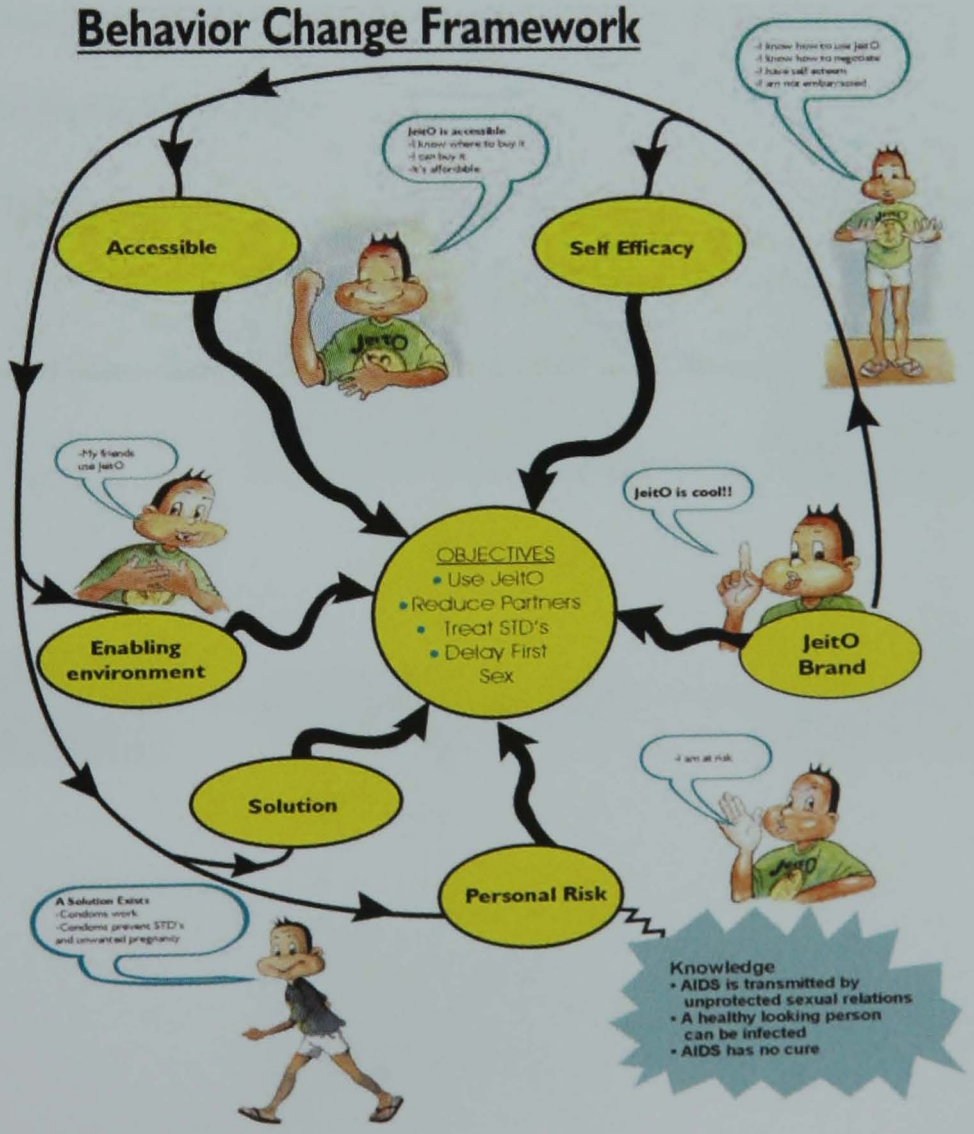
Once the *Jeitoso's* Pathway model was articulated, it soon became clear the model did not fully satisfy the needs of the Project. The dissatisfaction with the model by the Project mirrored that found in the literature: the lack of distinct divisions between stages, the linear

progression of the model, the focus on individual cognitive behaviours at the expense of larger group/societal level processes (Bunton, Baldwin, Flynn et al. 2000). Specific to the *Jeito* Project, the model did not incorporate brand attributes. The fact the Pathway suggested a linear progression in a simplified form proved to be controversial for the Project. Project partners' (other NGOs, MoH, etc) reaction to the model indicated that it was a gross oversimplification and failed to account for failure, backtracking, and relapse. Accordingly, the Project sought a more comprehensive model to encompass what was seen as the multi-disciplinary and synergetic nature of the Project.

### *3.2.2 The Jeito social marketing behaviour change model*

The focus on behaviour change theory led the *Jeito* Project to develop the *Jeito* Social Marketing Behaviour Change Framework (SMBCF) (see Graphic 5). The SMBCF, like the Pathway model which came before, is an amalgam of several individual-level models. The SMBCF was used to guide project activities, train and orient staff, evaluate intervention activities, and promote the Project to stakeholders (Karlyn 1998b).

***Graphic 5: A social marketing behaviour change framework***

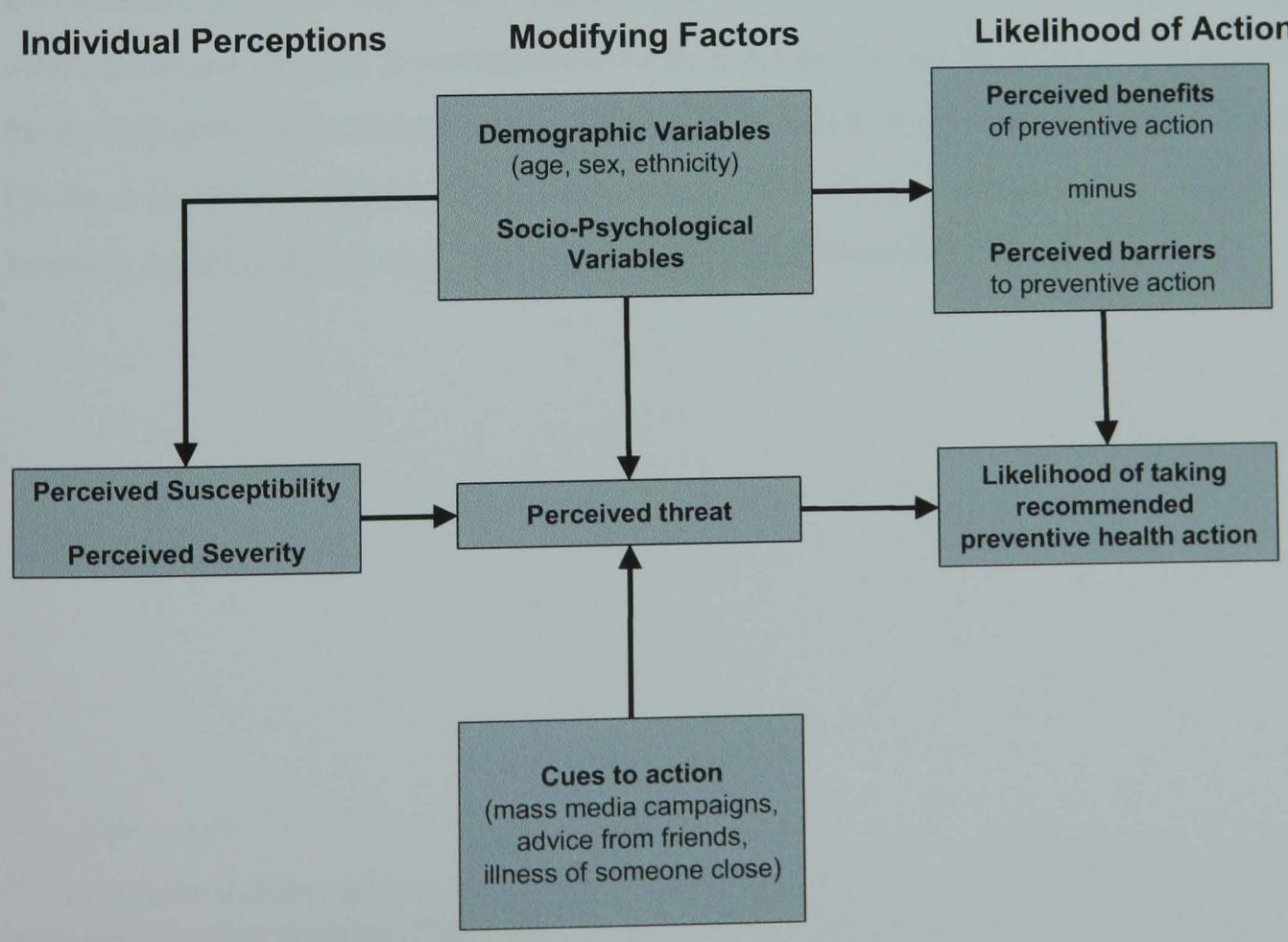



Source: Stallworthy, Karlyn and Davis (2000)

The first two factors of the SMBCF, personal risk perception and solution efficacy, are derived from the Health Belief Model (HBM), which is the first and most widely applied behaviour change model (Becker 1974). Personal risk perception is a composite indicator comprised of awareness, perceived threat and perceived personal risk. Solution efficacy, as conceptualised by the *Jeito* model, represents the proximity of the threat to the individual and the confidence one has the proscribed action may lead to a positive result.

The HBM hypothesises that two principal factors determine individual behaviour: first, an individual must feel personally threatened by the disease; and, second, the benefits of taking a preventive course of action are effective and outweigh the expected barriers (costs) (see Graphic 6). Perceived threat is a composite variable consisting of awareness, perceived severity, and perceived personal risk. It captures the subjective perception of the risk in contracting an illness. Solution efficacy is closely related to the HBM construct of perceived severity, which is the expectancy of the consequences of contracting an illness or leaving it untreated, including the clinical as well as social consequences. Lastly, the HBM includes a mechanism to activate behavioural outcomes known as cues-to-action such as mass media campaigns, advice from others, illness of a family member or friend, etc.

***Graphic 6: The health belief model***




Source: Bowes (1997)

The two SMBCF factors associated with normative influences on behaviour include enabling environment and self-efficacy. Enabling environment refers to the socio-normative factors which support or inhibit the adoption of risk practices and take the form of attitudes and beliefs. Self-efficacy refers to the personal characteristics associated with the belief that one has the ability to change one's behaviour, anticipating a positive outcome. These elements are found in The Theory of Reasoned Action (TRA) (Rosenstock, Strecher and Becker 1994), the Theory of Planned Behaviour (TPB) (Ajzen 1988), and Social Learning Theory (SLT) (Bandura 1986; 1994). The models share a common set of elements focused on individual cognitive processes leading to behavioural outcomes. Both the TRA and TPB postulate that intention to perform a behaviour is the immediate determinant of an action, modified by attitudes toward the action, and subjective norms. The TPB differs in that it adds the construct perceived behavioural control (see Graphic 7).

The two theories focus on the causal antecedents of volitional behaviours, assuming individuals behave rationally based on available information and the perceived expected outcomes of their actions (Ajzen and Fishbein 1980; Ajzen 1985; Ajzen 1988; 1991; Madden, Ellen and Ajzen 1992). Fishbein *et al.* (1994) review the many applications of the TRA and TPB across a variety of behaviour change interventions.[20] In HIV/AIDS prevention interventions, the TRA was used to identify the underlying belief constructs contributing to condom use and attitudes toward pleasure-seeking, sexual enjoyment, social norms related to family and peers, and external socio-demographic variables in the model (Catania, Dolcini, Coates et al. 1989; Valdiserri, Arena, Proctor et al. 1989; Hingson, Strunin, Berlin et al. 1990; Jemmott, Jemmott, Spears et al. 1992; Fishbein, Middlestadt and Hitchcock 1994).

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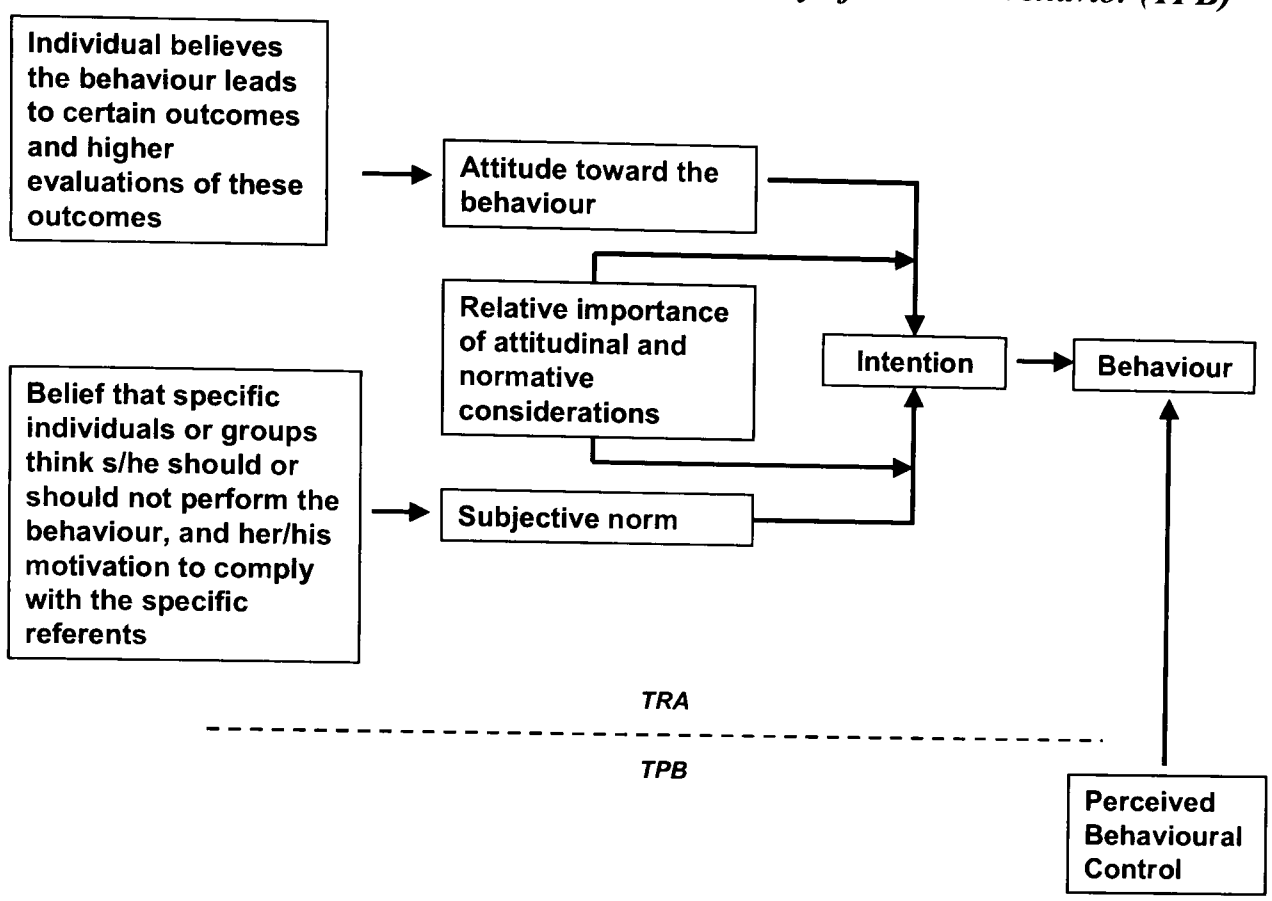
[20] This includes abortion, adolescent criminality, alcohol consumption, breast self-examination, breastfeeding, career decisions, church attendance, consumer purchasing habits, contraceptive decision making and use, cooperation, exercise, family planning, involuntary automobile restraints, job seeking, Lamaze childbirth, philanthropy, smoking cessation, substance abuse, university lecture attendance, voting, and weight loss.

*Graphic 7: The Theory of Reasoned Action (TRA) and Theory of Planned Behavior (TPB)*




Source: Ajzen and Fishbein (1980)

Both the factors of enabling environment and self-efficacy are primarily influenced by attitudes, both positive and negative, toward the subjective evaluation of performing a behaviour. These are knowledge-driven assessments derived from the cumulative experience of the individual. Attitudes are influenced by subjective beliefs that a given outcome will occur because of an action as well as evaluation of the outcome itself. Subjective norms are the perceived social pressures to perform the proscribed behaviour based on an individual's immediate peer group and larger social reference group. They are influenced by individual beliefs about what normative supports and sanctions exist with regard to the behaviour and depend upon four criteria: the action, target, context, and time (Carter 1990). A change in the structures underlying a behaviour should result in a change in the outcome behaviour (Fishbein, Middlestadt and Hitchcock 1994). Thus both enabling environment and self-efficacy are the result of changes in the social support and sanctions associated with carrying out an action.

Social Learning Theory (SLT) represents an attempt to integrate multiple levels of individual cognition and action. SLT views behaviour as a reciprocal model consisting of a) personal determinants including cognitive, affective and biological factors, b) behavioural intent, and c) environmental influences (Bandura 1986). Behaviour is learned either through a modelling process through vicarious, symbolic, and self-regulatory processes, or by direct observation of others. The process relies on the continuous interaction between cognitive,

behavioural and environmental determinants. Complex behaviour is determined through a framework of self-regulation using skills and motivations based on internal rules, affective reactions, self-monitoring, and intentions. Self-regulation is predicated on two additional factors: outcome expectancies and self-efficacy (Bandura 1977a; Strecher, DeVellis, Becker et al. 1986). The SMBCF borrows these components of SLT. Here, outcome expectancy is the same as solution efficacy discussed above.

***Graphic 8: Social learning theory***

| Concept | Definition | Application |
|---|---|---|
| Reciprocal Determinism | Behaviour changes result from interaction between person and environment; change is bidirectional | Involve the individual and relevant others; work to change the environment, if warranted. |
| Behavioural Capability | Knowledge and skills to influence behaviour | Provide information and training about action. |
| Expectations | Beliefs about likely results of action | Incorporate information about likely results of action in advice. |
| Self-Efficacy | Confidence in ability to take action and persist in action | Point out strengths; use persuasion and encouragement; approach behaviour change in small steps. |
| Observational Learning | Beliefs based on observing others like self and/or visible physical results | Point out others experience, physical changes; identify role models to emulate. |
| Reinforcement | Responses to a person's behaviour that increase or decrease the chances of recurrence | Provide incentives, rewards, praise; encourage self-reward; decrease possibility of negative responses that deter positive changes. |

Source: Bowes (1997)

Interventions based on SLT focus on skills building to enhance condom negotiation, reduce barriers to condom use by emphasising positive aspects and minimising negative associations of their use, and address environmental barriers impeding risk reduction. This is in an integral activity within the *Jeito* Project where the social modelling of risk reduction interactions is incorporated into the *fogo cruzado* peer education activity described in detail in Chapters 4 and 6.

Self-efficacy cuts across all the behaviour change models, except for the HBM, and forms an important component of the SMBCF model. In a meta-analysis comparing behaviour change models, SLT was found to have an equal or greater effect on outcome behaviours across all 12 interventions reviewed (Greenberg 1996). Evidence for the role of self-efficacy in changing health behaviours has been found in research on substance abuse (Rosenthal, Moore

and Flynn 1991) and increased self-protection among gay men (McKusick, Coates, Morin et al. 1990). Interventions using interpersonal communications demonstrate that self-efficacy can be raised through skills enhancements, peer support, and skills modelling (de Vries, Dijkstra and Kuhlman 1988; Frutchey 1989; Boer, Kok, Hospers et al. 1991). Once raised, self-efficacy can augment the effectiveness of other behaviour change elements across settings and groups.[21]

The SMBCF is typical of AIDS prevention in developing countries where the intervention approach represents a mixture of theoretical models and techniques ostensibly to maximise the benefits of each. While the interdisciplinary nature of these models may be attractive for the practitioner initially, the mixture of theory can result in a model which is atheoretical rather than transtheoretical. The divergent theories configure the relationship between motivation, cause and effect in fundamentally different ways. The intervention arising out of each theoretical model would also differ based on the assumptions built into each theoretical paradigm (Bunton, Baldwin, Flynn et al. 2000). However, the result of mixing and matching may contribute to the loss of reflexivity by project staff in which implicit assumptions bring unintended or little understood consequences. Later, I put forth a graphic representation of this intervention effect in order to show how interventions embody assumptions about how behaviour change happens. At the same time, interventions try to accommodate local perceptions of change in the form of cultural sensitivity. The result can be far from the mark in terms of actual representations young people offer about HIV/AIDS, risk, and condom use.

### 3.3 Behaviour change interventions: Critiques, successes, and implicit assumptions

To this point, I have reviewed how behaviour change has been incorporated into theoretical models using the *Jeito* Project as an example. These models reflect the evolution of the field of behaviour change, and guide interventions for HIV/AIDS prevention based on a set of explicit and implicit assumptions. In this section of the chapter, I review the limitations inherent in individual-oriented models of behaviour change. I then review the successes found to date in applying behaviour change to HIV/AIDS prevention. Lastly, I focus on how the implicit assumptions derived from behaviour change models shape and limit the potential outcomes of interventions.

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[21] See O'Leary (1985); Bandura (1989); Siegel, Mesagno, Chen et al. (1989); Slater (1989); Brafford and Beck (1991); Kok (1991); Maibach, Flora and Nass (1991); Rosenthal, Moore and Flynn (1991); Basen-Engquist and Parcel (1992); Kasen, Vaughan and Walter (1992); O'Leary, Goodhart, Jemmott et al. (1992); Walter, Vaughan, Gladis et al. (1992); Heinrich (1993).

### 3.3.1 *Critiques of individual led behaviour change models*

Most behaviour change interventions function by limiting potentially risky situations and social relationships, and by targeting risk perceptions, attitudes, self-efficacy beliefs, risk reduction skills, intentions, and outcome expectations (Kalichman and Stevenson 1997). Many models exist. An early review of the field found over 14 different models, each with its own set of constructs, variables, assumptions, and caveats. Nevertheless, a high degree of commonality was found among the variables used to construct them (King and Wright 1991).

Nearly all focus on the individual as the primary unit of change. Individual-focussed behaviour change models portray prevention as rational processes based on knowledge, social norms, behavioural intentions, or perceived vulnerability. However, they fail to fully explain how risk behaviours are perpetuated. In reducing complex behaviours into a set of rational constructs, the context of the sexual encounter is often lost (Auerbach, Wypijewska and Brodie 1994; Amaro 1995). In part, their limitations may be due to measurement error of key constructs (Catania, Kegeles and Coates 1990; Ferry, Deheneffe, Mamdani et al. 1995; Konings, Bantebya, Carael et al. 1995). According to Bolton (1989), this reflects a disciplinary bias found in evaluation research of sexual behaviour which relies on self-reported descriptive data on the number of sexual partners, condom use, partner type, etc. These indicators lack sufficient detail on the context of reported sexual behaviours necessary for the design of STI/AIDS prevention programmes across groups. While proponents of these models emphasise the need to contextualise sexual behaviour, the leading theorists in the field concluded the context of sexual risk can neither be conceptualised nor defined clearly enough to be measured by these models (Fishbein, Bandura, Triandis et al. 1991). Consequently, alternative approaches are necessary to consider the individual and social impediments that limit the adoption of safer sexual practices (Hearst, Mandel and Coates 1995; Lamptey, Kamenga and Weir 1997).

Individual-level behaviour change models over-estimate individual rationality, which assumes: deterministic, consistent and predictable relationships between cognitions, attitudes, intentions, and behaviours; and, static levels of knowledge, attitudes, and perceived risk and severity (Ingham and van Zessen 1997; Moatti, Hausser and Agrafiotis 1997). Such models reduce a diverse set of characteristics influencing sexual behaviour into broad and simplistic categories (Ferrand and Snijders 1997). For example, the link between perceived severity and cost within the HBM is further weakened by the delayed onset of symptoms, thus mitigating the immediacy of threat and severity of cost. Individuals focus on other, more immediate short-

term costs such as the fear of rejection by a partner, diminished sexual pleasure, or violence (Catania, Chitwood, Coates et al. 1990; Rosenstock, Strecher and Becker 1994; Ingham and van Zessen 1997). Lastly, the separation between dependent and independent variables used by behaviour change models can be artificial and the direction of a causal link misjudged. Knowledge is used to justify behaviour after the fact (Bastard and Cardia-Voneche 1997).

A meta-review of forty-six studies confirms the utility of the Health Belief Model to predict behaviour change across several health outcomes (Rosenstock 1990). The most powerful single factor found in the model was perceived barriers, while perceived severity the least predictive. Janz and Becker (1984) found a strong positive association with elements of the Health Belief Model and behavioural outcomes in several health interventions.[22] However, the model failed to account for temporal variations in threats, a critical issue for HIV/AIDS prevention as the onset is delayed. For the same reason, the model fails to predict behavioural outcomes when applied to chronic health issues (Becker 1974; Rosenstock 1974; Janz and Becker 1984; Becker and Joseph 1988; McLeroy, Bibeau, Stckler et al. 1988; Rosenstock 1990; Rosenstock, Strecher and Becker 1994; Bowes 1997).

The growing attention by social scientists to the meaning of sexual behaviour has led to greater emphasis on the context of sexual interactions. Many authors have examined the various perceptions of risk leading to individual decisions to engage in unprotected sex (Lindan 1991; Kline, Kline and Oken 1992; Moore and Rosenthal 1992; Keller 1993; Gielen, Faden, O'Campo et al. 1994; Romero-Daza 1994; Lear 1995; 1996). Unprotected sex can be considered rational when taken within the context of the objectives for entering into and maintaining a sexual relationship – conferring such benefits as emotional intimacy, trust, legitimacy, and economic security (Sibthorpe 1992; Pivnick 1993; LeFranc 1996). Disbelief in the existence of the AIDS or as a conspiracy to limit sexual activity is common among young people (Farmer 1992; Keller 1993; Schoepf 1993; Green 1994; Romero-Daza 1994).

The denial of risk may be attributed to a coping mechanism to avoid confronting a partner about past sexual partners. Such situations may lead to embarrassment or the dissolution of the relationship (Worth 1989; Sibthorpe 1992; Keller 1993; McGrath, Rwabukwali, Schumann et al. 1993; Pivnick 1993). Further, attitudes toward risk are often bi-directional. Individuals underestimate risk to justify their behaviour (van der Pligt, Otten,

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[22] Including Tay Sachs screening, breast self-examination, hypertension screening, seatbelt use, exercise, nutrition, smoking, physician visits, and drink driving.

Richard et al. 1993). In such cases, unprotected sex may be a form of escapism or emotional detachment from the reality of HIV risk. Finally, an individual's perceived isolation from high-risk groups, a generalisation often predicated by AIDS prevention programmes, precludes the need for behaviour change (McKirnan, Ostrow and Hope 1996).

Risk perception forms an integral part of most individual-based theoretical models of health behaviour (Poppen and Reisen 1997). A sense of vulnerability, both immediate and personal, is assumed to motivate self-protective behaviours. The self-assessment of personal risk has an important influence on risk mitigation practices such as voluntary testing. Those who exhibit high risk practices, but do not consider themselves at risk, are less likely to either volunteer for HIV testing or to return for the results (Wortley, Chu, Diaz et al. 1995; Fichtner, Wolitski, Johnson et al. 1996).

### *3.3.2 Building on successes: Community-based interventions*

After nearly 25 years since the first cases of HIV/AIDS were reported, advances in both the prevention of transmission and treatment through antiretroviral therapy have changed the prognosis of HIV infection from a certain death sentence to one of management of a chronic illness. For most of the developing world however, the lack of a viable therapeutic alternative means that prevention efforts to change sexual behaviour will continue to be the primary tool to stop the spread of HIV infection. Important successes in changing sexual behaviour have been documented, both in developed and developing countries (Hogle, Green, Nantulya et al. 2002; Low-Beer 2003). Research-based interventions using one-on-one counselling sessions, small-group seminars and community-level initiatives have been successful in reducing risk behaviours among gay and bisexual men, in school youth, and other high-risk populations (Kelly 1999). Other advances have been made in the treatment and control of STIs (Grosskurth, Mosha, Todd et al 1995a; Grosskurth, Mosha, Todd et al. 1995b), anti-viral therapies to prevent vertical transmission (Garcia 1999; Mofenson 1999; Rogers 1999), blood screening, new barrier methods such as the female condom (Warren and Philpott 2003), and microbicides (Potts 2000). Initial prevention efforts have succeeded in raising the awareness of HIV and knowledge of HIV prevention to nearly universal levels. Nevertheless, risky sexual behaviour persists and the epidemic continues to spread unabated (UNAIDS 1998). Even among the most affluent and well educated, prevention practices are considered inconsistent and prone to relapse (Hays, Kegeles and Coates 1990; Adib, Joseph, Ostrow et al. 1991; Kelly, Murphy, Sikkema et al. 1993).

Interventions that explicitly recognise a structured health behaviour change framework are more successful than those that do not (Holtgrave, Qualls, Curran et al. 1995). Green and Kreuter (1991) note that successful interventions integrate change theories from the beginning of the design process, through implementation, to evaluation. Efficacy will be limited if an intervention fails to adapt their behaviour change model to programme objectives, the targeted behaviour, contextual issues, and target group characteristics. Consequently, the replication of successful pilot programmes in one area does not necessarily correspond to successes in other areas. The use of behaviour change theories in a particular context requires an understanding of the subtle processes that contribute to behaviours, beyond a template view of interventions (Glanz, Lewis and Rimmer 1990).

In a classic review of the intervention literature, Kelly, Sikkema and Holtgrave (1989) note the essential elements of successful programmes. Behaviour change interventions are most effective if they focus on changing the psychological and social characteristics that influence the risk-taking behaviour of a given population or community. Effective intervention programmes integrate the following objectives into their activities: change normative perceptions about the social desirability of risk reduction steps; strengthening behaviour change intentions, attitudes, and perceived efficacy of change; and, increase target population skills and motivation to use those skills to resist coercion to engage in unwanted or unprotected sex and to negotiate safer sex practices. Through peer endorsement of behaviour modification messages (Holtgrave, Qualls, Curran et al. 1995), community-level interventions have proven to be effective at tailoring intervention elements toward several populations (Kegeles, Hays and Coates 1996; O'Reilly and Piot 1996; Kelly, Murphy, Sikkema et al. 1997; Prochaska and Velicer 1997; CDC and The AIDS Community Demonstration Projects Research Group 1999; Kelly 1999).[23] Skills-based interventions, often based on theoretical approaches to communications, have sought to improve skills in active learning and reflection. These interventions seek to string together positive life narratives that embody protective practices (Boyer and Kegeles 1991; Jemmott, Jemmott and Fong 1992). The challenge lies in expanding pilot interventions into large-scale community-based interventions that work across multiple sites and target populations. Furthermore, most pilot interventions are developed in rich country settings but applied to low-income countries (Kelly 1999).

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[23] This includes women, gay and bisexual men, college students, school and non-school based adolescents, individuals in STI and family planning clinic settings, prisons, and injecting drug users.

The most prominent case of societal-level behaviour change in a low income country setting is Uganda. A recent review of the evidence suggests that Uganda did indeed experience a decrease in incidence of HIV infection, most likely due to a combination of factors, including delay in sexual initiation among young people, abstinence, partner reduction, political commitment, and condom use (Hogle, Green, Nantulya et al. 2002).[24] Condom use was found to be an unlikely explanation for the initial drop in rates in 1992. Others have questioned the validity of indicators such as reported condom use, sex outside marriage, and number of casual partners (Ngugi, Plummer, Simonsen et al. 1988). This would have required high condom use starting three years prior to this date to avert new infections. Subsequent increased condom use in the mid to late 1990s did appear to have slowed the spread of the epidemic. DHS data from 1989 indicates only 1% of Ugandan women had ever used a condom, compared to 6% in 1995 and 16% in 2000. For men, condom use increased from 16% in 1995 to 40% in 2000 (Hogle, Green, Nantulya et al. 2002). Allen and Heald (2004) posit that the limited promotion of condom use early on in the epidemic, combined with a broadbased response to the epidemic by key political and social leader in Ugandan society, resulted in the domesticisation of the response and creating greater ownership of AIDS prevention by society as a whole.[25]

With the exception of Uganda, prevention efforts have yet to produce positive changes in risk practices on a societal level. Campbell (2003) explains why behaviour change interventions have thus far failed, and how community-level interventions offer important advantages. Prevention interventions fail because they are dominated by biomedical and behavioural models of sexual behaviour. They ignore the underlying determinants of sexual behaviour and sexuality, and instead focus principally on individual determinants of sexual practice and thus use models that reflect this. They underestimate the complexities influencing individual behaviour, such as STI treatment seeking. They overlook the biological explanations as instinct or emotion driven behaviours (Campbell 2003).

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[24] Parkhurst (2002) argues the drop in prevalence reflects a political bias as well as a bias associated with sentinel surveillance among antenatal clinics.

[25] Alternative explanations as to why HIV prevalence rates dropped in Uganda point to the moral sanction against poly-partnering. Further speculation holds that multiple epidemics were concurrent in Uganda and behaviour change happened at different stages among different groups, undermining the argument for a broad-based change in morality. More importantly, rates of infection surged in the late 1980s and early 1990s due to war and social disruption. The end of the war and rapid demobilisation, resettlement and return to economic stability has contributed greatly to remove the factors driving the epidemic.

Community level analysis has largely been ignored in the AIDS literature. Communities are important because they form an essential link between macro and micro processes which may enable or inhibit individual action. Communities reflect the structural factors affecting individual practice, including the economic and social processes leading to poverty and gender inequalities. Communities need not be considered contiguous or geographically bound. Membership in a community reflects one's social identity and social/economic position. Lastly, the power of collective action has been largely ignored. Communities provide an important impetus in getting people to act in mutually beneficial, health enhancing ways (Campbell 2003).

Community-level programmes may use naturally occurring channels of influence such as social networks, civil society, and other institutions to create an enabling environment that encourages the adoption and maintenance of healthy lifestyles (Peterson and DiClemente 2000). However, community-level interventions must be tailored to individual contexts specific to vulnerable populations within communities (DiClemente 2001).

### *3.3.3 Implicit Assumptions*

Despite the promise of community-level models, Campbell (2003) demonstrates that even under the best of circumstance, it can easily all go wrong. The assumptions made about what works are often predicated on shaky ground. Stakeholder consultation can create the façade of participation, but not alter the fundamental power relationships that drive resource allocation in a specific context. Likewise, methods such as peer education do not function in a vacuum. Peer educators are subject to the same social and economic constraints as the community as a whole. Campbell asserts that peer education lacks a theoretical base and fails to learn from success and failures (Campbell 2003)

In this next section, I take a closer look at the peer education methodology and give examples from the literature to demonstrate the limitations of the methodology. Specifically I use the example of peer education show how implicit assumptions inherent in individual-oriented approaches to AIDS prevention can undermine programme efficacy. I then return to the *Jeito* SMBCF to show how the same implicit assumptions apply to the *Jeito* model.

Lessons from peer education

Peer education is considered an effective method to deliver a behaviour change message across a wide variety of interventions, health behaviours, and target groups (Kirby 1984; Sepulvede, Fineberg and Mann 1992; Sloane and Zimmer 1993; FHI AIDSCAP 1996).

As a channel of message delivery, it is flexible in accommodating the needs of the individuals targeted. It works well in low resource settings with limited media coverage, low literacy, and a high degree of cultural diversity. The methodology maximises interpersonal contact with their target audience through face-to-face encounters and small group sessions (McKirnan, Ostrow and Hope 1996). Behaviour change messages can be targeted toward identified high-risk behaviours and a corresponding group or community – some examples include prisoners (Vaz, Gloyd and Trindade 1996), factory workers (Mbizvo, Latif, Machekano et al. 1997), sex workers (Ngugi, Wilson, Sebstad et al. 1996), and traditional medical practitioners (Green 1994).

The promotion of STI/AIDS prevention through peer education interventions does not always correspond to the reduction of risky sexual behaviour (Lindsey 1997). Laub, Somera, Gowan, *et al.* (1999) propose that one explanation for the failure of peer education to promote behaviour change is the role of underlying, implicit theories of sexuality, gender, and risk found in youth sexual culture. Interventions fail to challenge the implicit assumptions associated with the many theories and practices used in HIV prevention activities. Moreover, most prevention activities fail to accurately identify and incorporate into their interventions valid explanations of sexual risk of their target populations. Little attention is given to gender roles and ideologies which form the basis for internalised beliefs and expectations. Moreover, peer pressure can encourage conformity to gender-based norms of sexual behaviour with negative consequences.

Peer education interventions, like most behaviour change methods, rely upon a limited set of intervention elements based on information, consequence-focused change messages, skills modelling, attitude modification, and assertiveness training. These elements are based on implicit assumptions that often go unrecognised by the intervention agent (see Annex 11.3). Among sexually active young people, information-based activities assume that young people lack key information related to the transmission of HIV and the consequences of unprotected sexual intercourse. However, awareness and correct information about STI/AIDS is nearly universal among young people in urban areas across sub-Saharan Africa. Accurate prevention information, while an essential precursor of behaviour change, is not sufficient to change risk behaviour and requires considerable modification to accommodate differences in age, sexual relationship types, and stage-of-change of the target group (Fisher and Fisher 1998).

Fear-based or consequence-focused prevention messages have been shown to raise awareness and intention to change risk behaviour, but relapse is often high (Witte and Morrison 1995). Recognising one's own vulnerability to AIDS is not sufficient to change behaviour.

Likewise, there is little value in learning condom negotiation techniques when faced with the deeply rooted behavioural patterns and coping mechanisms that contribute to sexual risk-taking (Levanthal 1970; Rogers 1975; 1983; Job 1988; Kirby and DiClemente 1994). In fact, fear arousal messages can promote negative reactions leading to the stigmatisation of people living with AIDS (PLWA), emotional coping, and fatalism (Bastard and Cardia-Voneche 1997; Meursing 1997; Wellings and Field 1997; Caldwell, Orubuloye and Caldwell 1999).

Peer education is considered to be well suited to deliver skills-building exercises to a target audience. This assumes, however, the target audience engages in risky behaviour because they lack the skills necessary to practice safer sex (Kirby 1992). While skills modelling and role-play promote safer sex behaviour (Eisen, Zellman and McAlister 1990; Howard and McCabe 1990; Kirby and DiClemente 1994; Smith and Katner 1995) and delay sexual initiation (Kirby 1984), they are not associated with sustaining behaviour change over time, especially if counteracted by cultural norms that proscribe the contrary (Kirby and DiClemente 1994). Similarly, the use of assertiveness training and confidence-building exercises to offset the effects of peer pressure may underestimate the strength of one's social reference group and prevailing norms (Fisher, Misovich and Fisher 1992). Peer pressure is not a tangible entity that can be directly confronted; rather it is the social reinforcement of how one should behave. If the underlying motivations and social context of sexual relations are not addressed, the success of prevention efforts will be limited (Aggleton 1989).

The implicit assumptions limiting peer education are not restricted to the content of the peer education activity, but to the methodology itself as a communication channel. Prevention programmes incorporating peer education assume that young people prefer a peer rather than an adult role model or health education professional to teach them about HIV/AIDS prevention.[26] Consistent with diffusion of innovation theory (Rogers 1995 [1983]), young people often cite their preferred source of information as those with greater technical expertise in the subject matter (doctors, nurses, AIDS hotlines, etc.) (Valente, Poppe and Merritt 1996; Roffman, Stephens, Curtin et al. 1998). Lindsay (1997) contends that credibility, a function of the expertise and trustworthiness exhibited by the source, is often confused with sympathetic characteristics of the peer based on familiarity, attractiveness, dynamism, charisma, or empathy toward the reference group. Improving the credibility of the source does not change the quality

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[26] According to Social Learning Theory, advice seeking extends from one's immediate social circle outward to the larger social reference group.

of the message, and can result in a "credible, ineffective message" (Laub, Somera, Gowen et al. 1999:191).

Finally, peers do not necessarily represent the finest of examples. Many peer education interventions seek to empower the peer educator to promote behaviour change not only in the lives of others, but in their own lives as well, and recruit members of a target group to carry out peer education activities (Asamoah, Weir, Pappoe et al. 1994; FHI AIDSCAP 1996; Broadhead, Heckathorn, Weakliem et al. 1998). The peer educator does benefit from participation, as evidenced by increased mastery of the subject matter as well as self-esteem (Sloane and Zimmer 1993). Nevertheless, peer educators do not always follow their own advice and fall victim to many of the behavioural outcomes they seek to prevent, including unwanted pregnancy, STIs, and HIV/AIDS (Balmer, Gikundi, Billingsley et al. 1997). However, the characteristics and skills sought after in recruiting good peer educators often lead these individuals to move on to better jobs, such that these interventions are victims of their own success. As a result, the burden of training and continuing education is often under-estimated in peer education activities.

Implicit assumptions in the Social Marketing Behaviour Change Model

Returning to PSI's SMBCF, the same kinds of implicit assumptions found in the critique of peer education can be found in the model. For instance, the awareness component of personal risk perception seeks to increase knowledge about HIV/AIDS, STIs and condoms, and assumes that young people lack accurate information about these topics. Knowledge of means to prevent infection similarly assumes young people are ignorant of the mechanism of transmission, as well as assuming an individual has the power to use such information in their relationships. However the reality is just the opposite. Young people are aware of HIV/AIDS and the mechanism of transmission. Their perception of the relevance of this information to them, however, is in doubt.

The skills-based activities assume young people lack the ability to assert their needs and desire within relationships. However, skills are limited to the ability to talk to one's partner and to negotiate the use of a condom. As we shall see in future chapters, young people demonstrate enormous skill in negotiating risk contexts; however condom use is not necessarily the outcome they are negotiating for.

External factors influencing youth behaviour are addressed in the SMBCF by attempting to affect larger social norms as well as promoting greater inter-partner and

intergenerational communication around issues of sexuality. Support for social networks assumes young people cannot talk to their partners, parents, and significant others about sensitive topics like sex, condoms, or AIDS. The social norm approach assumes young people will face the risk of HIV/AIDS only if society as a whole accepts them as sexual beings, rather than as innocents or deviants. Promoting intergenerational communication, also, makes assumptions about how families in places like Maputo are constructed and what role parents should take vis-à-vis their children. Even supposing that parents could potentially broach such sensitive topics with their children, the *Jeito* Project targeted young people with these messages rather than their parents. When parents were targeted, the Project met considerable opposition from conservative elements in society and dropped the issue.[27]

Finally, brand identification as a behaviour change factor presumes that a brand can promote the adoption of a safer sexual lifestyle. The promotion of condoms for sale presumes that young people do not use condoms because of physical, economic or social barriers. Branding avoids potentially negative associations between the product and promiscuity, disease, or reduced pleasure. It also facilitates the distribution of the product through the private commercial sector where the condom brand can be promoted and sold at a fair mark-up. Once those barriers are removed, young people will adopt the use of condoms more readily.

The implicit assumptions contained in the SMBCF illustrate how an intervention translates theory into practice and shows how unidirectional the process of behaviour change promotion can be. The significance of the various presumptions found in the model, and thus the intervention, ignores the logic of risk avoidance already in practice by young people. This internal logic is explored in Chapter 6 through two intervention activities to show how risk dominates sexual interactions. Risk reduction strategies may not correspond to the practices proscribed by the intervention and may not result in greater condom use. I examine how these multi-layered objectives are imparted in the context of an intervention activity, a targeted radio campaign carried out by PSI.

### 3.4 Alternative approaches to behaviour change

How interventions contain and perpetuate implicit assumptions illustrate the complex range of social and cultural meanings associated with behaviour change and sexuality (de

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[27] A television commercial in 1998 attempted to address the issue by portraying a concerned mother handing a condom to her daughter. The advertisement was pulled when the MoH expressed their concern the scene was unrealistic in the eyes of Mozambican society.

Zalduondo 1991; Parker, Herdt and Carballo 1991). Despite the recognition of this complexity, interventions continue to target high-risk groups rather than the specific high-risk practices espoused within a sexual culture (Kelly 1999). With the expansion of small-scale pilot interventions to scaled-up multi-level initiatives, programme planners are forced to rethink implicit assumptions contained in intervention methodologies about sexuality, risk groups, risk behaviour, and communities.

A number of conclusions can be drawn from the literature on sexual behaviour: sexuality is a poorly defined, documented, and understood phenomenon; the structure and form of relationships are complex; and relationships change over time (Abramson 1992). The recognition that sexual behaviour is deeply embedded in larger systems of meaning has prompted a call for analytical approaches that include the political, economic, and socio-cultural determinants of high-risk sexual practices (Worth 1989; Ulin 1992; Dixon-Mueller 1993; Balmer, Gikundi, Kanyotu et al. 1995; Cleland and Ferry 1995). Phenomena such as condom negotiation and use, number of sexual partners, and dry sex must be interpreted within a cultural framework that conditions beliefs and decision-making (Taylor 1990; Runganga, Pitts and McMaster 1992; Ulin 1992; Brown and et al 1993; Preston-Whyte 1994; Setel 1995).

To address these lessons, researchers have applied anthropological and sociological methods to describe cultural variation of sexual behaviours and risk (Reiss 1986). Through the use of ethnographic and systems-oriented studies, greater emphasis has been placed on understanding of the effects of sexual orientation on risk and subsequently reinterpreting the concept of risk within the changing structures of sexual relationships across lifecycles and relationship systems (Carrier and Bolton 1991).

The shift toward understanding the structure and meaning of sexual relations has led some theorists to adopt a framework for the study of sexual relations focusing on the dyad and interpersonal models of sexual interaction (Ingham and van Zessen 1997). Instead of isolating individual determinants of behavioural outcomes using constructs like those found in the HBM, dyadic approaches stipulate that couples negotiate their sexual behaviour based on the social expectations bound to their respective individual, partner, and group expectations. Thus, sexual relations are a product of interpersonal interactions and represented by the activities and social meaning attributed to the dyad (van Campenhoudt, Cohen, Guizzardi et al. 1997). The construct of interactional competence, put forth by Ingham and van Zessen (1997), suggests that knowledge of individual sexual behaviour is incomplete without consideration of their partner's characteristics. Who the partner is (their identity, age, sex, and experience), what type of

relationship they have, what they do together, when, how and why all contribute to the meaning of sex and thus the behaviour they perform. Within this framework, sexual partnering is analysed in terms of partner selection, partner change, differentiation in sexual practice by partnership type (primary versus secondary partners), and sexual decision-making based on representations of partner types (Giami and Dowsett 1996).

In summary, a consensus has emerged across several disciplines for the use of a phenomenological approach to broaden the understanding of sexual behaviour. As illogical as sexual behaviour may seem, it tells an important story about the participants, their lives, and the practice they adopt. To understand the logic of unprotected sex, I present script theory as an important tool to understand sexual behaviour within the context of a behaviour change intervention. As we have seen, individual models of behaviour change may predict factor contributing to risk outcomes, but do so at the expense of context and types of relationships. Stuctural models of behaviour change that focus on normative influences on individual behaviour, but likewise fails to incorporate individual variation in sexual practice and risk taking. Script theory in the form of sexual scripts, acoomodates the competing tensions of structure and agency. As an alternative to established behaviour change theories, script theory offers a cohesive framework to assess theoretic as well as programmatic characteristics of behaviour change interventions. For these reasons, the remainder of this chapter focuses on script theory as applied to sexuality and risk-taken.

### *3.4.1 Sexual scripts*

The notion of sexual scripts is derived from script theory (Gagnon and Simon 1973), and has been used as a research tool in the areas of sexuality and HIV/AIDS prevention (Simon and Gagnon 1986; Gagnon 1988; Gagnon 1990; Maticka-Tyndale 1991; Parker and Gagnon 1995a). While the disciplinary origin of script theory is in sociology, the theory has found a home in the study of human sexuality among social psychologists as well anthropologists. Social psychologists often use scripts in a literal sense to examine descriptive narratives, such as the ideal romantic scenario (Ortiz-Torres, Williams and Ehrhardt 2003). Most articles documenting the use of scripts in social psychology acknowledge the larger sociological phenomena associated with scripts – i.e. scripts reflect gender ideology – nevertheless, the

approach is reductionist in that scripts are identified and then tested for consistency across groups and time.[28]

In contrast, I approach script theory from the sociological perspective. I use script theory principally as a framework and metaphor to identify sexual practice, how it is organised and adapted to accommodate perceptions of risk (Simon 1996). In doing so, I attempt to demonstrate how structure and agency contribute to youth sexuality in Maputo. A social constructionist approach is applied to identify the underlying norms and behavioural patterns that contribute to youth sexual identity. These norms are embodied in the sexual scripts employed by young people and ultimately come into question as young people are forced to modify their scripts as a result of individual interactions with different types of partners, as well as larger structural factors which influence norms. Script theory fits well with the interactional competence framework put forth by Ingham and van Zessen (1997) and helps to demonstrate how socially constructed roles create a specific discourse and mode of interaction between partners and thus determine how risk perceptions become translated into behaviour. Scripts also provide a useful metaphor to view youth sexuality because they are easily understood and represented by young people themselves, allowing them to represent their sexual identity in the context of risk. The temporal nature of scripts helps to limit often complex sets of actions and emotions into a finite, descriptive event. In short, youth sexual scripts illustrate what it means to be young in Maputo today. They reflect larger norms or cultural scripts that tell one how to act in certain situations. In documenting the predominant sexual scripts used by young people in Maputo, I focus on one such script, the *saca cena*, to examine how some individuals have adapted it to fit changes in identity due to the threat of HIV/AIDS (see Chapter 8).[29]

Script theory, presented in Graphic 9, challenges the interpretation of sexuality as solely biological. Building on the interpretative approaches set forth by post-modern theories of sexuality, script theory considers sexuality as a culturally determined phenomenon, meaning different things to individuals in different cultures (Gagnon 1990). Patterns of sexual behaviour

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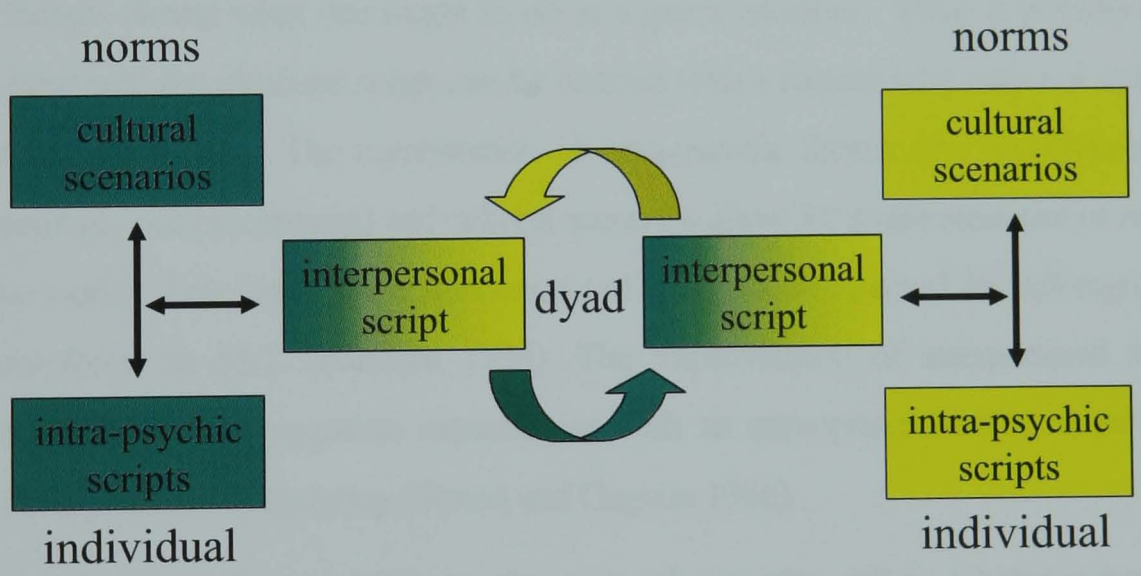
[28] see Tomkins (1978); LaPlante, McCormick and Brannigan (1980); Gagnon, Rosen and Leiblum (1982); see Baumeister (1988); Mosher and Tomkins (1988); Kirsch (1989); Rose and Frieze (1989); Kyes, Brown and Pollack (1991); Atwood and Dershowitz (1992); O'Sullivan and Byers (1992); Edgar and Fitzpatrick (1993); Osullivan and Byers (1993); Rose and Frieze (1993); Ecker (1994); Mosher and Macian (1994a); Mosher and MacIan (1994b); Byers (1995); Meischke (1995); Gilmore, DeLamater and Wagstaff (1996); McKirnan, Ostrow and Hope (1996); Carpenter (1998); Frey and Hojjat (1998); Hynie, Lydon, Cote et al. (1998); Weis (1998); Diekman, McDonald and Gardner (2000); Kvalem and Traeen (2000); Seal, Wagner-Raphael and Ehrhardt (2000).

[29] Literally translated, *saca cena* means to take the scene. In the context of sexual practice, it refers to a one-night stand or casual sex with someone whom you never met before or know only superficially.

are acquired through a process of acculturation based on predominant norms, and include both deviations from and embellishments to the basic sexual scripts found in a specific culture. This approach refutes the concept of sexual instinct or drive, a view with historic origins in early studies of sexology that has instilled itself into popular discourse (Lauman and Gagnon 1995).

Script theory has been criticised as a simple heuristic for guiding the individual through a complex process of sexual negotiation, failing to account for both individual agency and structural determinants of sexuality (Gagnon 1990). These criticisms were addressed by distinguishing scripts into three separate elements: cultural scenarios, interpersonal scripts, and intra-psychic scripts. Cultural scenarios are the commonly held norms guiding gender and sexual conduct embedded in cultural narratives. Interpersonal scripts are expected sequences of events that represent mutually shared conventions of sexual behaviour. They facilitate the negotiation of a complex and mutually dependent act between two individual actors. Intra-psychic scripts are the plans and fantasies by which individuals guide and reflect upon their past, current, or future conduct (Lauman and Gagnon 1995).

***Graphic 9: Script theory diagram***




Sexual scripts are mutually shared behavioural conventions that permit the negotiation of a complex set of acts (courtship, foreplay, sexual intercourse) between two partners. They are organised cognitive schemas used by individual actors to recognise, engage, and negotiate a potentially sexual situation. Scripts focus on individual agency as a snapshot of a particular behavioural interaction, but situate the interaction within the context of larger cultural scripts that influence the degree and scope of individual variation – i.e. what is permitted in a given situation. As a metaphor, scripts illustrate the link between norms (cultural scripts) and practice (how young people come to do what they do) while providing a simplified framework with which to focus on sexual interaction at one point in time. Sexual behaviour is seen an

accumulation of these moments over time whereby individual experience, social context, and partner type combine to shape sexual practice. Thus, scripts are well suited to examine partner interactions (practice) without ignoring the role of norms and reflexivity that guide behaviour. They can be used to represent a complex interaction between the individual, his or her sexual partner, and the social context in which they interact. Scripts are individually defined and socially situated learned behaviours. They can be selectively used, modified, and adapted over time (Trotter and Schensul 1998). Scripts facilitate the negotiation and performance of a sexual encounter, delineating what is permitted and expected in a given situation (Middlethon 1997). They guide individual action through the regulation of sexual habits and norms, while allowing for individual manipulation and deviation (van Campenhoudt 1997).

Gagnon (1990) argues that cultural scenario provides the framework for narrative practice of specific roles, marking their boundaries, performance, and conclusion. They do not require, nor could enforce, a rigid imposition of a narrative even in the most traditional of settings. Given the high degree of heterogeneity in the practice of sexual relations, considerable interpretation and adaptation is required to meld the ideal proscribed by a cultural scenario with the actual. Scripts dictate what one ought to do in a given situation. What is actually done depends on how well the idealised script can be enacted with a partner who may not interpret the script in the same way. The combination of intra-psychic factors (the manipulation of symbols, meanings, and perceptions) and cultural scenarios allow for a safe rehearsal of how to interact in the world. This idea reflects the concept of social modelling and the self-regulation of behaviours found in SLT (Bandura 1994). The improvisation of interpersonal scripts empowers the individual to negotiate expectations with an appropriate identity; a narrative which may or may not prove enduring (Simon and Gagnon 1986).

The application of script theory to the study of sexuality strikes a balance between individual agency and societal norms in explaining young people's sexual behaviour. Scripts allow for learning not only the heuristics of sexual behaviour, but the "internal states" of meaning as applied to novel situations (Deven and Meredith 1997:152). Scripts can also represent formalised cognitive expectations that have taken on a ritualised set of interactions and habits (van Campenhoudt and Cohen 1997). For instance, in Western contexts couples often begin their sexual relationship using condoms and quickly opt for other forms of contraception once trust has been established. Scripts dictate the terms of sexual relations, guiding with whom, what forms, and where and when it takes place. Individual improvisation around cultural scenarios is part of a process of social action that creates and changes the sexual culture

of a society. Individuals as well as societal actors such as the mass media, religion, educators, researchers, and the medical establishment play a role in determining these representations of sexuality.

Scripts offer considerable stability in negotiating novel sexual situations. While changes in cultural scenarios over the lifecycle present new challenges to individuals and couples, most sexual scripts are learned during childhood and early adolescence when most experimentation takes place. Individual actors quickly learn which scripts work in terms of sexual gratification as well as social acceptability, and carry these scripts forward for future use. As cultural scenarios change, sexual scripts are used to confirm (or reject) the concomitant social roles and expectations associated with new identities and relationships. In this context, youth sexual expression can be interpreted not only as an expression of individual sexuality, but a marker of social acceptability as an adult through interpersonal as well as intra-psychic confirmation of a cultural scenario – the confirmation of man/womanhood through sexual expression. The same can be said in the case of older individuals (usually men) who engage in intergenerational sex as a means of confirming their status as young and virile (Simon and Gagnon 1986).

Unprotected sex is socially constructed and perpetuated by multiple levels of personal and social interactions. For some young people, sex is the means to gain status and maturity among one's social reference group, to prove and feel loved, and to avoid being left out of what their friends are doing. Condom use interferes with these objectives. Consequently, young people eschew condoms as a means of avoiding uncomfortable or threatening confrontations in which they have to talk about sex, undermine the spontaneity of the encounter, risk the loss of the opportunity to have sex, suffer the rejection by their partner, display distrust, and in the case of girls, risk being branded as promiscuous (Laub, Somera, Gowen et al. 1999). This rationale dominates young people's scripts of sexual interactions, thus illustrating the complex, interconnected relationships of beliefs and values linked to perceived gender roles and sexual scripts. Peer pressure is often the hidden force driving risk behaviour; however the typical young adult takes risks not because of peer pressure, but because that is just the way things are (Ortner and Whitehead 1981; Kendall 1995).

Inadvertently, STI/AIDS prevention programmes have contributed to the social construction of risk both at the individual and group level. Condom social marketing in particular perpetuates stereotypes by associating condoms with masculine images of virility. Brand identity often emphases masculine stereotypes. The socialisation of adolescent boys

emphasises autonomy, emotional distance, and pressure to achieve rigidly defined male roles. Across cultures, boys tend to be socialised to achieve and express their masculinity in an outward fashion – aggressive and competitive. They conform to a social expectation as providers and protectors. The developmental pathways leading to this role may be marked by rigid macho roles coded as honour and bravado. The expression of macho roles can lead to tests of courage through socially sanctioned aggressive behaviour including risk-taking, fighting, and sexual conquest. Viewing masculinity as a specific and discreet identity fails to account for the diversity of male identities found with a given society. Nevertheless, most cultures do exhibit a prevailing masculine script which serves as an icon to uphold, a standard to compare, and norm to deviate from (Barker 2000).

The meaning of sexual scripts depends as much on how they are promoted as how the intended participants perceive them (Gagnon 1990; Deven and Meredith 1997). Alternative concepts of health, illness, and self, shape perceptions of risk and the subsequent scripts used for guiding behaviour (Bastard, Cardia-Voneche, Peto et al. 1997). Diverse beliefs about disease causation exist with some subscribing more to biomedical views of disease ecology while others embracing a range of alternative local categories of disease causation (Foster and Anderson 1978; Kleinman 1980; Chalmers 1996). Individual and group behaviours are influenced by these beliefs (Caldwell, Orubuloye and Caldwell 1999) and illustrate the need for correspondingly appropriate sexual scripts to negotiate high-risk situations. Insight into the gap between knowledge and behaviour can be gained by considering local definitions of risk and corresponding risk-reduction measures including condom use. On an individual level, the labelling of certain sexual behaviours as high-risk and the subsequent association with specific socio-demographic groups contributes to this social construction (Schoepf 1993). On an institutional level, behaviour change interventions contribute to the social construction of risk through the transformation of the subjects of an intervention into risk groups programmatic objects to be manipulated rather than participants in the process of negotiating risk reduction (Moatti, Hausser and Agrafiotis 1997).

### *3.4.2 Innovators as a mirror of change*

This chapter has reviewed various models of behaviour change, and considered specific interventions that employ behaviour change methods. We have examined how behaviour change happens through script theory. What has yet to be answered is why certain individuals take on an active learning role while others do not.

One lens through which to examine the behaviour change process focuses on innovators. Who are they? What do they do that is innovative? How have they come to challenge dominant stereotypes and norms? What reflexivity and individual agency exists in driving this positive deviance? From the diffusion of innovation literature we know that innovators (early adopters) typically are more enterprising, more cosmopolitan, and of relatively higher socio-economic status than late adopters (Rogers and Shoemaker 1971). Innovators tend to give greater weight to personal needs and aspirations and, through active information seeking, manage to cope with uncertainty better than late adopters (Rogers 1995 [1983]). This may be due to active information seeking from both familiar and more reputable sources of information, while discounting unreliable and conflicting views of dissenters (Valente, Poppe and Merritt 1996). As such, certain individuals may see themselves as innovators and their actions are mediated by this self-image. Even without self-realisation that an innovation may have a functional advantage, in this case to reduce risk. Nevertheless, the association of a set of practices with a supportive identity does offer a functional basis for some young people to reduce risk on their own terms. Young people are particularly adept at assuming multiple sets of identities and associated behaviours that may both conform to and resist dominant social norms (MacPhail and Campbell 2001; Rivers and Aggleton 2001). It is the objective of the remainder of this thesis to identify not only that conformity but also that counter-normative deviance.[30]

As we have seen in Chapter 2, various factors that influence risky sexual behaviour in sub-Saharan Africa, including migration (Brockerhoff and Biddlecom 1999; Lurie, Williams, Zuma et al. 2003), current or past STI (Grosskurth, Mosha, Todd, et al, 1995a), high socio-economic status in early-stage epidemics (see Hargreaves and Glynn 2002), and early age of first pregnancy (Chao, Bulterys, Musanganire et al. 1994).[31] These studies, however, largely fail to explain the contextual factors as to why an individual may or may not engage in high-risk sex. Other factors may also aid in understanding the context of condom use such as peer norms and pressures; negative adult attitudes to youth sexuality; limited availability of condoms; and larger structural issues marked by gender relations, economic pressures, and the social

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[30] While I do not explicitly set out to test diffusion of innovation theory (Rogers 1995 [1983]), I do use script theory to operationalize the diffusion framework, which like Prochaska's Transtheoretical Model (Prochaska and Di Clemente 1983), has never adequately explained how one becomes an innovator.

[31] For more on the education/AIDS literature, (see Hargreaves and Glynn 2002) review the topic. Evidence is beginning to emerge to substantiate claims that better educated individuals eventually avail themselves of behaviour change messages to reduce their risk. (see Vandemoortele and Delamonica 2000; de Walque 2002).

construction of sexuality (MacPhail and Campbell 2001). A divergent area of inquiry has focussed on the relatively small minority of young people who challenge the traditional social constructions of relationships by taking on safer sex practices (Holland, Ramazanoglu, Scott et al. 1990; 1992).

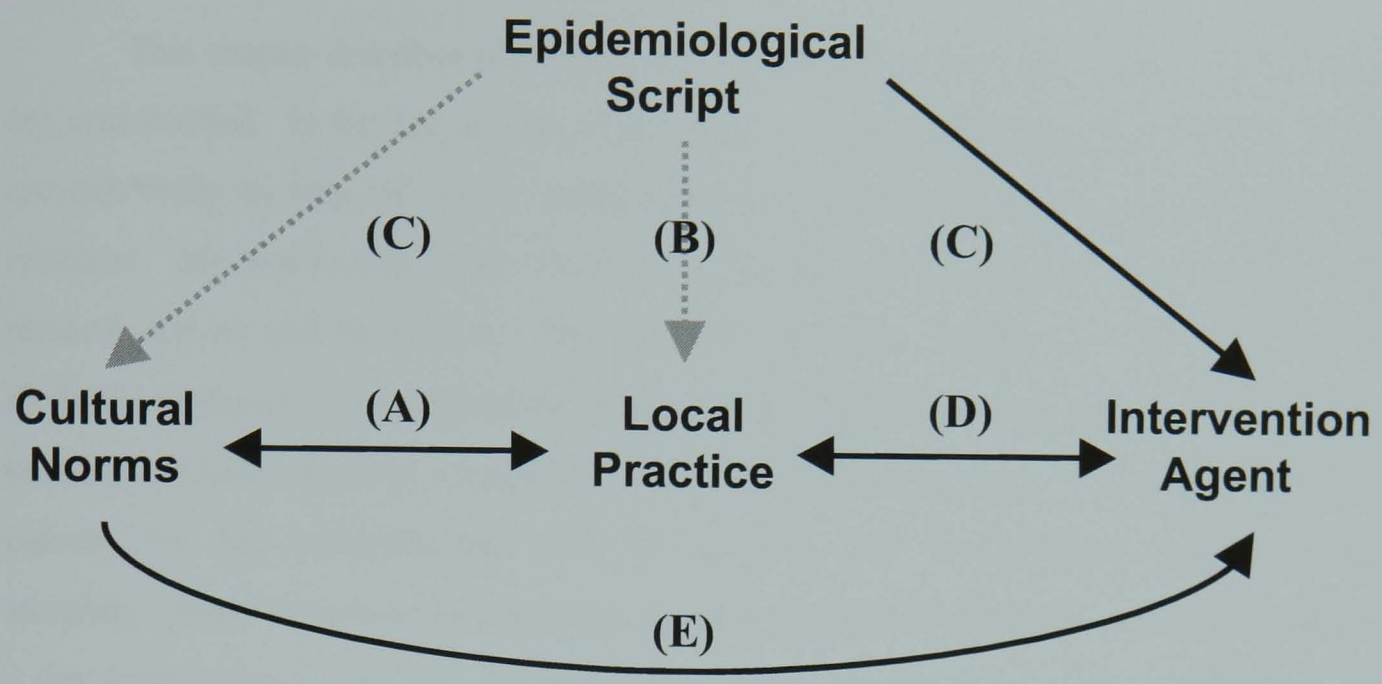
Reflexivity and self-awareness are important components of the change process. How one evaluates past and current experiences influences the attitudes and choices that she or he will bring to future sexual encounters. A lack of reflection upon past experiences may lead to failure to adapt sexual scripts to novel situations and reliance upon compulsion and reaction rather than introspection, active engagement, and will (Bandura 1986). The possibility of taking an active role in changing a particular sexual encounter depends greatly on these behavioural patterns and may be resistant to behaviour change messages (Ingham, Jaramazovic, Stevens et al. 1996).

### *3.4.3 The behaviour change process*

Social change interventions attempt to influence individual practice, but may also perpetuate many of the same biases that lead to risk practice. Without a clear understanding of how change happens, and how meaning becomes vested in practice, interventions will likely fail in promoting healthy lifestyles and prevent the transmission of HIV and STIs. Graphic 10 illustrates this process.

The behaviour change process is comprised of multiple directions and endogenous variables that are context specific. The intervention agent was included to accommodate the multiple sources of behaviour change messages that may impinge upon practice. While this was conceived to account for HIV/AIDS prevention interventions as the agent of change, it does not presuppose the likelihood of multiple agents of change promoting complementary and sometimes contradictory messages. The diagram does not attempt to portray a causative effect of a uni-directional nature. For example, a government agency may promote the use of condoms to prevent the spread of HIV and STIs, at the same time a church group may be spreading rumours to undermine the perceived efficacy of condoms as a means of prevention. The diagram does illustrate the reflexive process of change articulation common to behaviour change communications.

*Graphic 10: The behaviour change process*




Young people present their sexual practice in the context of (A) accepted norms yet assert their needs and desires in subtly subversive ways. The process of acting upon these needs and desires within the socially constructed context of sexual risk introduces changes in practice that subsequently guide further changes norms. In turn, this reflective process alters the manner in which young people present their practice. Epidemological scripts (facts) indirectly (represented by dashed lines) influence local practice as young people selectively apply fact to the risk identities they assume; indirectly epidemiological scripts (C) influence larger cultural norms as syncretic forms of myth and fact combine to form plurastic medical systems; and (C) directly influence the intervention agent (solid line) through behaviour change theories founded in epidemiological theory. A reciprocal relationship between practice and intervention agents exists (D), since interventions purport to target the specific needs of a group and often incorporate participatory methods to evoke the expressed desires of elements of that group. Finally, an intervention exists as part of a social environment and conforms implicitly and/or explicitly to the dominant cultural milieu (E).

The behaviour change process illustrated in Graphic 10 captures the basic theoretical foundation explored in the thesis and incorporates the divergent theories of behaviour change reviewed in this chapter. The model demonstrates how behaviour change works at both macro and individual levels. By examining the role of interventions in perpetuating specific discourses of behaviour change, I focus on one intervention's attempts to alter sexual practice. Script theory is used to frame sexual interactions and allow for an analysis of the implicit assumptions driving sexual practice.

# 4 STUDY DESIGN AND METHODS

This chapter describes how the research presented in this thesis was planned, carried out, and verified. In the first section of the chapter, I present the planning and design of the research study to help the reader understand how and why the study was conceived and executed. My relationship to the Project is explained and a distinction drawn between the research activity and the Project. This section includes the objectives of the study and the methods employed. I also explain the selection of the sample and study location. In the second section, I describe the data collection process, from staff recruitment and training, informed consent, the data collection and verification process, and the participant recruitment and sampling. Here I document the challenges faced in conducting fieldwork on sensitive topics in a developing country context. Changes introduced in the field as a result of difficulties and limitations found are noted. Third, I describe how the data management cycle was organised, verified, and analysed.

This thesis is a purely qualitative study. The choice of methods reflects the objective of the study as stated in Chapter 1. Qualitative research, as applied here, is exploratory and naturalistic because it studies a group in its natural setting and seeks to formulate hypotheses rather than test them (Patton 1980). This tradition of inquiry contrasts with quantitative inquiry which is confirmatory and deductive in nature. The difference in approach is far from absolute, but does represent distinct ontological traditions (Lincoln and Denzin 2000). The qualitative approach chosen for this project can be considered "generic qualitative research" as distinct from grounded theory which seeks to build theory or purely ethnographic work that describes culture (Caelli, Ray and Mill 2003:3). This approach is relativist in the sense that I sought to capture the reality of young people's sexuality in a particular time and space.

Some practical reasons contributed to the choice of methods. Qualitative methods are especially appropriate to approach the sensitive nature of sexual behaviour (Pelto and Pelto 1978; Bolton 1992; Denzin and Lincoln 1994; Pool 1997). At the same time, considerable quantitative data had been recently collected in Mozambique. Four nationally representative surveys had been conducted between 1996 and 2000, including the Mozambique National Census (1997), a World Bank/GRM Living Standards Measurement Survey (1998; 1998), the DHS (1997c) and PSI's own NAPS survey on sexual behaviour and condom use (Karlyn and Monjane 1998). However, few qualitative studies on the topic had been undertaken. Resource constraints in programme implementation precluded the use of intensive qualitative methods.

The research study was an opportunity to redress this issue. The Project was also interested in pursuing an in-depth investigation into the context of risk which had eluded the Project so far using quantitative instruments.

Before considering the design process, I will first give some background on the context in which the data were collected. A detailed description of the *Jeito* Project is given in Chapter 1. Here I discuss my relationship to the Project and how the objectives of my PhD research coincided with the Project's research aims.

## 4.1 Planning

From April 1995 until December of 1998, I held the position of Research Director for the *Jeito* Project. I was hired to establish a research unit and to design and implement research interventions to meet the Project's programme and reporting needs. The research encompassed a variety of areas of health behaviour including studies of private sector distribution systems, mass media interventions, consumer intercept surveys, and a national KAP survey of sexual behaviour. Most of the studies were quantitative, although qualitative research was undertaken to support the design and implementation of the quantitative studies related to questionnaire design, non-response, and validation of sexual behaviour data.

On leaving PSI Mozambique in December 1998, an agreement was made with the Project's Director to develop a research proposal to address the apparent gap between knowledge and practice among young people. The Project provided financial and material support including staff, transport, facilities, computers, and financing. The Project also facilitated contact with the Ministry of Health to gain approval for the research activity.

While the planning of the study design went smoothly, the scope of the study and timing proved to be a challenge. As a PhD research activity, I sought to cast a wider net of interview subjects and informants than the Project saw as necessary. The compromise worked out was twofold; the Project accepted a month delay in the initiation of the research activity while I conducted key informant interviews with important stakeholders. These stakeholders included NGO field level staff, technical advisors at the MoH and UN agencies, and academicians.[32] In turn, I agreed to provide a report to the Project with preliminary results prior to leaving the country. Project staff would accompany the activity for 3 months, except for my

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[32] At the request of PSI, the process of key informant consultation was kept informal to prevent the activity from becoming captured or subsumed by the interests of competing agencies.

research counterpart who was to take part in the report writing process. Annex 11.4 provides a timeline of the fieldwork phase of the study.

Another issue arose over the objectives of the activity. Was it an assessment, an evaluation, or an exploratory study? If the study were a true programme evaluation, the design of the research intervention should have included a rigorous means of testing and controlling for the results observed. However, my intent was to conduct an exploratory study of the meaning and context of risk among young people in Maputo. I sought to build hypotheses through open-ended research methods, which provided insight into why young people engaged in risk practices even though they were aware of the threat of HIV around them. Through the iterative process of exploring this topic, I sought to give voice to young people so that their concerns, world view, and conceptualisation of risk would be reflected in the *fogo cruzado* and other project activities.

How then did the language of programme evaluation end up in the research proposal? This question mirrors a central issue taken up by this thesis. AIDS prevention interventions, especially those associated with international NGOs, possess an organisational culture that values the scientific process. This culture emphasises a degree of (quasi) scientific determinism, focus, and efficiency. The proposal reflected this determinism and satisfied the Project's expectations in terms of objectives, outputs, and methods. Project management never required a rigorous evaluation method to be used.

Another key challenge surfaced on arrival in country. Changes in project staff and the re-prioritisation of resources left fewer project staff available to participate in the research activity. Instead of using project staff exclusively, I recruited four university students as research assistants from the Social Science Faculty (UFICS) at the University of Eduardo Mondlane (UEM). This resolved the problem of collecting individual interviews, but the research assistants had little experience conducting group interviews such as focus groups and no experience with the *fogo cruzado* methodology used by the Project. To address this limitation, two senior staff from the Project were seconded to the research activity on a part-time basis to conduct the *fogo cruzado*. Nevertheless, the lack of skilled group interviewers forced me to scale back the objectives of the *fogo cruzado* component of the activity, and place more emphasis on the individual interviews.

In the end, the changes in field implementation affected the results of the study by focusing the analysis more on in-depth contextual data rather than the *fogo cruzado* method.

Recruiting external staff had the beneficial effect of requiring a more in-depth and extensive training workshop at the beginning of the activity. In addition, the delay in organising focus group discussions meant that more individual interviews were conducted at the beginning of the research activity. The limited participation of the moderators meant fewer *fogo cruzado* activities were completed. In the end, more individual and group interviews were completed than planned. The Project report reflected this shift in priorities and thus could not give a detailed assessment of the *fogo cruzado* methodology. Some actionable changes to the behaviour change scripts arose from the research study and were presented to the Project, however this fell short of the objectives initially set out for the Project.

Lastly, my role as an independent researcher conflicted with my status as a former employee of the Project. My status as a former employee allowed for greater access to Project resources, however I was limited to the extent that I could direct those resources. At the same time, my association with the Project could be seen as a conflict of interest, particularly in terms of the objectivity of reports and evaluations I authored while working for the Project and cited in this thesis. On the former issue, I document at the beginning of this Section how collaboration with the Project impacted on the results of the study. In terms of the latter issue, I can only declare the potential conflicts of interest inherent in the study and point to the fact that many of the evaluations I authored and cited in the thesis were subjected to peer review.

### *4.1.1 Thesis objectives*

This thesis seeks to improve the understanding of the sexual behaviour of young people in Africa, the normative context in which it takes place, and how this differs from the assumptions guiding behaviour change interventions. To this end, the research associated with this goal sought to: 1) describe patterns of youth sexual practice in Maputo in 2000 and the risk context in which it takes place; 2) critique the normative assumptions of the PSI *Jeito* behaviour change intervention in Maputo in 2000 and to analyse the breadth and scope of interpretation of its messages by the target audience; 3) investigate and analyse how gender and power relations in this setting define and control sexual identity and determine sexual behaviour choices among youth; and, 4) understand how and why some young people in Maputo come to terms with risk, redefine their sexuality and, in the process, adopt innovative sexual behaviour, including condom use.

### *4.1.2 Thesis methods*

The study design employed rapid ethnographic techniques to examine sexual identity, partner interaction dynamics (gender roles, locus of control, and inter-partner communications),

perceptions of risk and trust, coping strategies, and social/cultural norm formation and attribution (Scrimshaw, Carballo, Ramos et al. 1991).[33] Emphasis centred on individual and group meanings linked to a wide range of sexual customs, focusing on societal linkages. Qualitative methods have been used successfully to describe hidden or inaccessible risk practice, and permits an integrated approach to contextualise risk within the changing structures of sexual relationships across life spans and types of relationships (Carrier and Bolton 1991). Efforts to adapt such methods specifically to the topic of sexual behaviour and high-risk groups such as commercial sex workers and intravenous drug users has met with considerable success and acceptance (Price and Hawkins 2002).

The methods employed by the study included individual open-ended semi-structured interviews (SSIs) and focus group discussions (FGDs). SSIs provide a structure for the exploration of common topics, allowing for a comparison of topics across interviews, without being too restrictive. The open-ended responses, when combined with appropriate probing and investigation, provided substantial in-depth information (Scrimshaw, Carballo, Ramos et al. 1991; Bernard 1995).[34] The use of triangulation of more than one source and research methodology further enhanced the rigour of the methods (Bernard 1995).

FGDs provided a structured environment in which common issues were explored. Careful manipulation of the FGD setting helped to establish an open and dynamic environment for participants to discuss issues of sexuality while creating appropriate boundaries for maintaining confidentiality and privacy. FGDs allowed for a greater understanding of social interactions in small group settings, as well as provided immediate feedback to contextualise individual participant views about the scripts and prevention messages presented in the group (Morgan 1988; Kitzinger 1994; Bernard 1995). Scepticism that focus groups are less appropriate to address sensitive topics such as sexuality has been proven largely unfounded (Wellings, Branigan and Mitchell 2000).

The data collection strategy and moderator guides were based on examples provided in Ingham, Jaramazovic, Stevens, *et al.* (1996) and predicated upon script theory (Gagnon and Simon 1973). The analysis presented in this thesis documents the predominant behavioural scripts that form the basis of partner interaction and negotiation of condom use.

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[33] The study cannot be considered a true ethnography due to the limited scope of the study (Pelto and Pelto 1978; Kendall 1995; Bernard 1998).
[34] See Annex 11.5 for the interview topics and sample questions.

The moderator guides for group and individual interviews were developed and pre-tested in the field. The guides underwent six iterations using the technique of saturation taken from grounded theory. The saturation method refers to the process of exploring lines of inquiry (in the form of themes and categories) until they fail to yield new or additional results, after which new topics are raised (Baker, Wuest and Stern 1992; Strauss and Corbin 1998).

Questionnaire instruments and moderator guides

The research study required three distinct data collection instruments: a screening questionnaire, an SSI moderator guide, and a FGD moderator guide. The screening questionnaire was required to triage potential participants into the sampling strategy. Separate moderator guides were developed for the SSI and the FGD since the topics and methods differed. The topic guides focused on risk mitigation by using condoms as well as other strategies of partner selection. Partnership types were investigated along with the norms and expectations associated with each, the perceptions of risk and trust negotiated within these partner contexts, the terms by which sex is negotiated (locus of control, power relations, gender); the modes of communication used; and, appropriateness of communications per risk context. Here, I present a brief review of the topics covered by the respective guides and the methods employed. English translations of the instruments are found in Annex 11.5.[35]

The SSI began by gathering basic socio-demographic data from the respondent. In the case of the FGD, these data were collected in the screening questionnaire to ensure privacy. Subsequently, the SSI guide explored relationship issues related to the individual's childhood, formative experiences, friendships, schooling, social life, religion, state of health, and family dynamics. The interview sought an inventory of resources available to the individual in terms of social support, health care (including reproductive health services, contraception, and condoms), and emotional support from partners, friends and family. The SSI guide focused the questions on the individual by gathering factual data around significant events, whether harmonious or conflictual. The strategy treated responses as social facts, and tried to capture respondent interpretation of events and their feelings toward them at the time they occurred and currently.

Once a degree of rapport had been established, the interviewer sought to create a sexual life history of the informant. The sexual life history covered the full sexual career of the

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[35] Portuguese language originals of instruments and guides are available upon request.

individual. The specific time points were recorded, first sexual feelings, first intercourse, and the most recent intercourse. The relationship type was established for each of the latter two points, and the use of condoms was examined thoroughly to establish the dynamics of condom use per partner and per act. This included questions regarding who suggested the use of the condom, who provided it, how it was received, when it was applied, and if it changed the sexual act in any way.

Particular attention was given to the context in which each experience occurred, the expectations and intentions on entering the relationship, the physical surroundings, the course of events as they unfolded, the use of condoms or other contraception, the sense of awareness and control around the event, and the feelings associated with it at the time and afterwards up to the time of the interview.

A script theory framework was applied and data captured to indicate the heuristics of the sexual event, the intra-psychic script of the individual, and the cultural script to the extent the individual may or may not have been aware of the rules underlying behaviour.[36] This latter issue was investigated by eliciting normative statements from the individual, such as "if you wanted your boyfriend to perform a specific sexual act, do you feel that you could have asked him to do so at that time? How would you have felt by asking?"

On exhausting the topics associated with sexual history, the interview turned toward an assessment and reflection of risk associated with the individual's experiences. The guide established how risk was conceived, whether one felt she or he could control the events in one's life, and how that control might be relevant to the future. The impact of HIV/AIDS on the informant's future was explored in terms of the informant's personal understanding of the disease from a physiological as well as social perspective. The potential impact of HIV/AIDS on the informant was elicited in terms of sexual practices, relationships, and condom use. The interview concluded by allowing the informant to express his or her ideal future in terms of romantic relationships, family, career, and dreams.

Similar topics and elicitation techniques were employed during the FGDs, however methods differed significantly due to group dynamics and the introduction of the *fogo cruzado* narrative technique. The aim of the focus group differed from the SSI. Instead of exploring individual information, the FGD explored the language, values, and meanings that arise in

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[36] This refers to the expectations associated with one's internal assessment of what one should do in a given circumstance.

conversations young people engage in with their peers. The specific aim of the FGD was to explore the following topics:

- the mode and manner of conversation around sex and sexuality among young people;
- social and sexual pressure felt by young people, and manner with which it was dealt;
- risks associated with relationships and sex, and how that risk was negotiated;
- condom use including when, how, and why condoms are used by young people;
- information about HIV/AIDS, including its aetiology, origin, transmission, and impact the lives of young people;
- safe sex, including how it was defined, practiced, and promoted through communications and social mobilisation campaigns; and,
- sex, what it is, how it is practiced, at what age should one start, what it means to engage in different practices (including same sex intercourse), what contexts lead to sex, what taboos are associated with it, and why.

To broach such sensitive topics as these in a group setting, the FGD began with an icebreaker exercise meant to put the participants at ease, as well as set the context for the forthcoming discussion. Careful consideration was given to the composition of the group as it can have an important impact on group dynamics. The study sought homogenous groups in terms of gender, age, educational background, and sexual experience. In a few examples, mixed gender groups were carefully recruited to explore diversity of views. The activity encountered dissenters but overall they added to the richness and diversity of the discussions.

Lastly, the FGD methods treated the interview as a single aggregate entity made up of individual views and group interactions. Issues of privacy and confidentiality were safeguarded by drawing limits to the personal nature of information presented by participants in the group. The moderator encouraged participants not to speak in the first person, but to couch their observations at the group level. For instance, if an individual was commenting on the early age of sexual maturity, the moderator would lead the commentary towards the experience of peers and not the direct experience of FGD members. Inevitably personal and private details did arise in the FGDs. Where this came of an individual's own volition to share such information, the moderator made a snap judgement whether to let it pass. If information was of a sensitive or personal nature that directly violated the privacy or integrity of others in the group, the moderator quickly intervened.

Narrative analysis using dramatisations and script improvisation

Narrative analysis methods were used extensively by the study (WHO 1992; 1993b; 1993a; Nnko and Pool 1997; Pool 1997; Senderowitz 1998; Harrison and Montgomery 2001).

The narrative method uses drama as a technique to aid participants act out scenes containing themes of sexuality, power, and relationships. Narrative analysis was used to systematically identify the dominant themes of sexual discourse among young people, including sexual behaviour and relationship types, as well as their social implications. For examples of studies using this technique see (Vanderford, Smith and Harris 1992; Balmer 1994; Varga 1999; Harrison and Montgomery 2001). The dramatisation allows for nuanced expression not always available to young people. The scenes used in the dramatisations were generated through individual and group interviews. The dramatisations also included scenarios taken from the *fogo cruzado* as a way of testing the dominant cultural concepts of sexuality used by Project activities.

The *fogo cruzado* peer education debate

The *fogo cruzado* is a dynamic, small group exercise which forms the principal interpersonal communication component of the *Jeito* Intervention. The activity is typically conducted by trained peer educators known as community agents with groups of about 15 to 20 participants. The community agents are employed directly by the *Jeito* Project and receive extensive training in group facilitation and moderation techniques. At the time of the study, a minimum of 15 *fogo cruzado* activities were carried out per month in each of Mozambique's 10 provinces as part of routine project activities.

The objective of the *fogo cruzado* is to encourage the participants to reflect on their risk of acquiring STI/AIDS and to help them adopt protective attitudes and abilities. The *fogo cruzado* is integrated with PSI's other activities including mass media (radio and television), sales, brand promotion, and theatre. Each of these activities promotes the internalisation of behaviour change on the part of the participant and leading to the adoption of safer sexual practices.

The activity consists of an introduction and three modules, with a total duration of 55 minutes. Module 1 consists of a 20 minute question-and-answer session in the form of an experiential back-and-forth debate. The objective of Module 1 is to evaluate one's own personal risk of acquiring HIV/AIDS or an STI, and to explore potential solutions. Module 2 provides a hands-on demonstration of how to apply a condom to a wooden model penis. The objective is to give the participants a chance to correctly handle a condom. The exercise takes about 15 minutes to complete. Module 3 consists of a series of dramatisations meant to force the participants to act out a risk scenario in which a less risky outcome is sought. The objective

of Module 3 is for the participants to learn how and gain confidence in negotiating the practice of safe sex.

Implementation of the *fogo cruzado* requires the completion of all three modules. However for the research activity, we focused solely on Module 3. Some added adjustments were made to adapt the activity including reducing the number of participants from 15-20 participants to 8-12 individuals.[37] The research activity used the behaviour change scenarios provided by the *fogo cruzado*, but added alternative scripts based on the results of individual and group interviews, or adaptations that arose during the *fogo cruzado*. The research activity encouraged the introduction of behaviour change scripts from multiple sources to examine how the Project's repertoire of risk reduction scripts commingled with the scripts presented by young people in the group, and to create a set of locally defined scripts. A set of scenarios was defined within the narrative methodology, and these formed the starting point of discussions regarding sexual scripts. Study participants were asked to act out these risk reduction scenes as dramatisations. The moderator explored the scripts presented as well as elicited adaptations of them from the participants (see Annex 11.9).

Of particular interest to the study was Module 3 which presents behaviour change scenarios or scripts to the group, and then selects two volunteers to act those scripts out as dramatisations. The moderator has a set of acceptable conclusions which she or he will guide the participants towards. In the case of a scenario that does not result in a positive ending, the moderator will use this as a discussion point for the group, and then encourage a re-enactment of the scenario to arrive at a positive outcome. Each scenario targets a specific group and models a behavioural response appropriate to that group as defined by the Project. Discussion points are given to the moderator to reinforce the impact of the scenario, and to ensure the participants not directly acting out the scene participate.

## 4.2 Data collection process and implementation of the study

### *4.2.1 Study location and timing*

Maputo was chosen as the field site because prior studies identified urban youth in Mozambique as vulnerable to the AIDS epidemic. As the centre of urban youth culture in

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[37] The fewer number of participants encourages active participation while providing a sufficiently broad range of personal experience (Douglas 1976).

Mozambique, Maputo was the logical choice.[38] Practical considerations also entered into the decision to conduct the research in Maputo. The Project headquarters were situated in Maputo, enabling the research activity to take full advantage of Project resources. The Project sought to use the research activity as a demonstration exercise for future expansion to other regions in the country. By conducting the activity in Maputo, key stakeholders could accompany the study implementation and results.

***Graphic 11: Maputo City Map***


Source: Jenkins (2000a)

The research activity took place over six months, beginning in January 2000. The activity consisted of a preparatory period in which key stakeholders were met, research staff recruited, and logistical arrangements made. A week training workshop was carried out with the study team and subsequently data collection was undertaken. Upon completion of the data collection, additional cleaning and coding the data were undertaken along with the initial data analysis. The preliminary write-up of results and local dissemination of through a series of seminars and programme meetings marked the end of the research activity. Table 2 below

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[38] See Chapter 1 for a full review of the literature on the situation of young people in Mozambique and Maputo.

summarises the implementation schedule. A detailed implementation plan is presented in Annex 11.6.

***Table 2: Summary of implementation schedule***

| Activity | Weeks |
|---|---|
| Preparation | 3 |
| Training | 3 |
| Data collection | 12 |
| Cleaning & coding | 3 |
| Report writing and dissemination | 2 |
| Total | 23 |

*4.2.2 Staff recruitment and training*

The study team consisted of 12 members, including two supervisors, six research assistants/interviewers, three data entry clerks, and one driver (see Annex 11.5). Training for the study consisted of theory and practice in rapid ethnographic methods, including individual/group interview techniques, data transcription, content analysis, and report generation. Both formal and in-service training methodologies were used and participants gained skills in individual interview techniques, focus group moderation, and field note taking. The training workshop was designed to hone the research staff's skills in fieldwork, but also to explore issues of sexuality, gender, and HIV/AIDS risk as a means of provoking the staff to gain greater insight into the complex issues they would be exploring with the study participants. This was especially important to ensure the privacy and confidentiality of the information they would be obtaining through the course of the interviews. By the end of the research activity, the study team was capable of carrying out a similar exercise on their own, from conceptualisation to analysis and report generation.[39]

*4.2.3 Informed consent, confidentiality and data ownership*

Informed consent was secured after a concise explanation of the purpose, use, and confidentiality of the individual interview data collected. Portable tape recorders were used to complement interviewer field notes. Prior consent to taping was required and confidentiality assured to the participant. The recordings were transcribed and confidentiality safeguarded through the anonymous coding of personal information (including name, residence, and other distinguishing details). Personal details were then be deleted from the transcripts. After

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[39] In fact, PSI successfully undertook a follow-on research activity (EquAR II) with the same core research staff in 2003.

cleaning, data were archived in a secure location by PSI and remain the property of PSI and the Mozambican National AIDS Control Programme.

Ethical review of the research protocol was submitted and approved by the Ethics Review Board of The London School of Hygiene and Tropical Medicine. The Mozambican NIH Ethics Review Committee also approved the protocol. A copy of the informed consent form is presented in Annex 11.7. Due to the lack of a local ethics review board to monitor the progress of the study, any questions regarding the conduct of the study were referred back to the the Office of the National Director of Health in the Ministry of Health. In addition to the provision for referral of ethical issues arising in the research, study staff received extensive training on techniques to ensure the privacy and confidentiality of respondents, both in the SSI and FGD interviews. This training included the use of informed consent, avoidance of stigmatizing topics (particularly during FGDs) that may betray other participants' privacy, and the avoidance of directly incriminating information related to child abuse, rape, or sexual abuse.

### *4.2.4 Participant recruitment and sampling*

Sample recruitment was undertaken using the "snowball sampling" method (Trotter and Schensul 1998:704-5). The method offers an efficient mechanism for reaching hidden or difficult to access populations and entails recruiting new subjects through individuals already interviewed based on specific criteria. The technique was applied for the recruitment of both group and individual interviews. While the sampling was purposive and not intended to be representative, care was taken to recruit participants with a sufficient range of experience by which scripts and condom negotiation could be explored. A screening questionnaire was applied to help in participant recruitment. All original interview materials, guides, control forms, and sampling plans can be found in Annex 11.5.

The sample was divided into cells based on demographic – age, sex, education – and sexual behaviour criteria. Participants were sought between the ages of 16 to 24 years old. An anonymous screening interview was undertaken to allocate an individual into an appropriate category. The screening form determined whether the individual was eligible to participate, but also to establish whether they fit the criteria for the interview required. Early in the interview process, few interviews were excluded. Later, as the sample cells filled up and themes became exhausted, some interviews had to be refused. FGD participants were further grouped into behavioural categories summarised as behaviour change in response to HIV/AIDS. This was a proxy indicator for the use of condoms as well as other behaviour change methods including partner reduction, fidelity, and abstinence (see Table 3).

*Table 3: Sampling plan*

| school attendance | in-school | | | | out-of-school | | | | total |
|---|---|---|---|---|---|---|---|---|---|
| age | <20 years | | 20+ years | | <20 years | | 20+ years | | |
| behaviour change | no | yes | no | yes | no | yes | no | yes | |
| males | 1/4 | 1/4 | 1/4 | 1/4 | 1/4 | 1/4 | 1/4 | 1/4 | 8/32 |
| females | 1/4 | 1/4 | 1/4 | 1/4 | 1/4 | 1/4 | 1/4 | 1/4 | 8/32 |
| total | 2/8 | 2/8 | 2/8 | 2/8 | 2/8 | 2/8 | 2/8 | 2/8 | 16/64 |

The sampling plan called for 18 FGDs and 64 SSIs. In practice, more interviews of both types were completed, totalling 21 FGDs and 71 SSIs. This was due to several factors. The initial delay in incorporating project staff into the research activity forced the postponement of the FGD moderator training module in the training workshop. Instead, the study team chose to focus on the SSIs first and then follow up with FGDs. Likewise, fewer *fogo cruzado* activities were undertaken because of staff constraints. The *fogo cruzado* is a specialised activity which required the participation of the Project's trained moderators. The delay in initiating the FGDs forced the study team to focus on SSI interviews. This is partially reflected in the results presented in this thesis. The SSIs produced fruitful descriptive data, as presented in Chapter 5. Follow-up to these themes was undertaken in the FGDs, however. As a result, the case studies presented in Chapters 7 and 8 largely reflect themes identified in SSIs but explored in detail in FGDs.

Difficulties associated with the SSIs centred on recruitment problems, especially for informants with no institutional affiliations such as out of school youth. In several cases, interviews were scheduled with alternate respondents because of loss to follow-up. Other impediments arose due to the sample recruiting process. Selecting respondents, especially those harder to find such as young people out of school, required selecting alternates to stand in for the originally scheduled interview. At times the RAs would double-book an interview, knowing that one of the two would not show up. In several cases, both respondents would appear and the RA was forced to conclude both interviews independently, even though only one was required for that sample cell. Approximately half of all recruitment contacts resulting in successful interviews. It should be noted that the interviews were recruited *in situ*, at schools, workplaces,

social and leasure venues young people frequented. Fortunately, once an interview was started, except for one occasion, the interview was carried to completion.

While schools facilitated the recruitment of respondents immensely, it should be noted that those who reach secondary school level are a select few. There is an inherent bias against girls as fewer make it to the secondary and tertiary education level than boys. Nationally 8.4 % of pupils drop out, and 26.5 % fail at the primary level (EP1 grades one to five). In grades six through seven (EP2) 28.3 % fail and 5% dropout. The attrition continues into secondary education: in grades eight to ten, 32 % of students fail, and 5 % drop out. In pre-university education (grades 11 and 12), 28.8 % fail and 0.7% drop out (UNDP 2000; AIM 2003).

### *4.2.5 Reliability and validity*

The reliability and validity of self-reported sexual behaviour data has been an issue since Kinsey undertook his famous study of sexual behaviour in the 1940s (Kinsey, Pomeroy and Martin 1948; Kinsey 1953). Kinsey took great lengths to ensure the quality of his data, including having his interviewers memorise the complete coding scheme so respondents would feel that their responses were anonymous and private. Of the 12,004 interviews attempted, Kinsey succeeded in interviewing 12,000 respondents (Morse, Barrett, Mayan et al. 2002). Much can be learned from these early attempts to investigate sexuality. The language and methods of validation have changed, but the basic premise holds. Rigour in research comes from the incremental process of verification, not from ex-post evaluation. I apply the same premise to the data collection strategy employed here. This section demonstrates how the process of verification of reliability and validity applies to the study of sexual behaviour.

Quantitative studies of sexual behaviour have used various test and retest techniques to validate their results (McLaws, Oldenburg, Ross et al. 1990; Brafford and Beck 1991; Snell, Fisher and Schuh 1992; Dare and Cleland 1994; Konings, Bantebya, Carael et al. 1995). The broad conclusion of these studies is that measures of sexuality, while containing biases, are stable and accurate. Nevertheless, there is evidence that men over-estimate and women under-estimate the number of sexual partners (Dare and Cleland 1994; Nnko, Boerma, Urassa et al. 2004). The reliability and validity of self-reported sexual behaviour obtained from self-administered questionnaires and face-to-face interviews is consistent with independent data sources (James, Bignell and Gillies 1991; Upchurch, Weisman, Shepherd et al. 1991; Walden, Mwangulube and Makhumula-Nkhoma 1999). In part, this may reflect overall changes in attitudes toward sexuality and improved knowledge of sexual health (Copas, Wellings, Erens et al. 2002).

Qualitative methods have become an established method of investigation and applied widely across the range of social science disciplines. Various studies have shown the utility of combined methods using both quantitative and qualitative techniques for the study of sexual behaviour (Wolff, Knodel and Sittitrai 1991; Bernard 1995; Blanc, Wolff, Gage et al. 1996; Weiss 2001) and purely qualitative methods using ethnographic techniques such as in-depth interviews, ethnographies and FGDs (Pool 1997; Dowsett, Aggleton, Abega et al. 1998).[40]

Like any instrument, a research technique or method can be misapplied. In a critique of Smith (1993a), Carael, Mertens, and Cleland (1993) acknowledge some of the limitations of quantitative KAP surveys, but make the important point that research is a means to an end – in this case to prevent the future transmission of HIV and STIs – and must be seen in the context they were conducted. The early KAP surveys initiated by WHO/Global Programme on AIDS were first attempts to systematically measure sexual behaviour and inevitably sample errors and instrument bias entered into the results (Carael, Mertens and Cleland 1993). Nevertheless, KAP surveys have helped to guide programme planning and evaluation for HIV control, especially early in the epidemic (Lane 1993). KAP surveys provide valuable population level data to establish overall trends, but causal links between programme interventions and behavioural outcomes are tenuous at best (Caldwell 1993). Caldwell (1993) further reinforces the point by demonstrating how data from different methods serves specific purposes. Sexual behaviour data from population level research provides information required for the development of epidemiological models and sexual networks, while qualitative information is needed to understand the relationship among epidemiological constructs.

Qualitative inquiry has been challenged over the reliability and validity of results. In part, this reflects the ontological tensions between quantitative and qualitative researchers, but centres on the integrity of methods used in qualitative research (Trochim 2002). It is not the intent or purpose of this chapter to review the qualitative vs. quantitative debate; however, it is important to note the debate extends beyond the question of ontological paradigms to include

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[40] An extensive body of literature exists of studies using qualitative techniques for the study of sexuality: Parker and Carballo 1990; Gil 1991; Wolff, Knodel and Sittitrai 1991; Abramson 1992; Trotter and Potter 1993; Ford and Kittisuksathit 1994; VanLandingham, Knodel, Saengtienchai et al. 1994; Balmer, Gikundi, Kanyotu et al. 1995; Calvès, Cornwell and Enyegue 1996; Ingham, Jaramazovic, Stevens et al. 1996; Middlestadt, Bhattacharyya, Rosenbaum et al. 1996; Balmer, Gikundi, Billingsley et al. 1997; Harrison, Lurie and Wilkinson 1997a; 1997b; Swart-Kruger and Richter 1997; Vasconcelos, Garcia, Mendonca et al. 1997; Agadjanian 1998c; Field, Price, Niang et al. 1998; Wood, Maforah and Jewkes 1998; Bohmer and Kirumira 2000; Harrison and Montgomery 2001; MacPhail and Campbell 2001; Silberschmidt and Rasch 2001.

political and sociological issues. Researchers and academicians invest heavily in the correctness of their adopted paradigms and disciplines. At the extreme, challenges to those paradigms or their ontological basis are thus unwelcome (Trochim 2002). Reliability refers to the quality of data, such that results are dependable, consistent, and stable. Validity refers to degree to which the research process reveals the truth with factual accuracy (descriptive validity), accuracy in representing the participants viewpoints, thoughts, intentions, and experiences (interpretive validity), and credibility of the theory derived from the study fits the data (theoretical validity) (Johnson 1997; Neuman 2000).

The challenging of reliability and validity in qualitative inquiry marks a dramatic shift in the field away from an emphasis on the procedures which ensure excellence in research, but toward the strategies for evaluating the quality of the results once completed (Morse, Barrett, Mayan et al. 2002). The result has been a paradigm effectively on the defensive. Indicative of this shift is Lincoln and Guba's (1985) concept of trustworthiness, which set forth separate criteria for measuring the utility of qualitative data. The constructs of reliability and validity are replaced by alternative criteria: including credibility, transferability, dependability, and confirmability.

I contend that these alternative criteria are but a repackaging of the quantitative criteria for assessing truth and rigour in research. They add little to the practice of qualitative research, although do give greater legitimacy to qualitative inquiry. Instead, the need to reformulate these criteria as new constructs only obfuscates the objective of introducing rigour to the process of inquiry.

### *4.2.6 Data collection and verification in the practice*

In this section, I review the procedures undertaken in the research study to ensure the highest degree of rigour possible. I emphasise the data collection process as an iterative cycle of analysis necessary to build reflectivity into the activity. The process of verification and correction is an integral part of the qualitative research process. Qualitative research is iterative and nonlinear. The line is often blurred between design and implementation as the ongoing analysis of results forces a constant reformulation of questions, development of new themes, changes in informant selection, and new data collection strategies. Verification is the process of incrementally ensuring the reliability and validity of the data at every step of the research process. Control mechanisms such as memos (field notes), member checks (using study participants to confirm results), and audit trails, ensure the process is well documented and transparent. These steps are sufficient to ensure reliability and validity for a post-hoc evaluation,

but unless used reflexively in the process of the research activity, overall rigour will suffer. Problems or shortcomings must be addressed as they arise and steps taken to correct them (Morse, Barrett, Mayan et al. 2002).

At every level, my research sought to control potential sources of bias, and correct them as they arose. Checks and balances were put into place from the inception of the activity. The research team consisted of a core of well trained individuals who formed a cohesive unit. Much of the logistical and financial control mechanisms already existed or were easily adapted to the specifics of the research activity, and this saved considerable time and energy in carrying out tasks such as paying salaries, ensuring fuel in the vehicles, making appointments, etc. The experience of the Project staff also helped in recruiting the RAs, developing a training curriculum, carrying out the training, pre-testing materials, and mapping out the sampling strategies. The research team was also well trained in qualitative research techniques including interview techniques, group dynamics, and note-taking necessary to undertake individual interviews, focus group discussions, and the *fogo cruzado*.

A number of steps were taken to minimise the likelihood of bias entering into the study. The moderator guides, interview procedures, coding schemes, and group moderation procedures were developed and pre-tested prior to the initiation of fieldwork. Great care was given to the construction and testing of survey instruments to minimise potentially misleading or offensive phrasing (Catania, McDermott and Pollack 1986; Bernard 1995). Contrary to the literature (VanLandingham, Knodel, Saengtienchai et al. 1994), my experience carrying out sexual behaviour research in Mozambique indicates the taboo around the topic of sexuality can easily be circumvented. The interview techniques emphasised the need to put the informant at ease. The topic of sexuality was built up to slowly to create rapport and rhythm in the interview. Once the topic of sexual behaviour was broached, it was done so directly and in a manner not to offend the individual. Kinsey (1948) observed that one should use language the subject is comfortable with, but be direct. For instance, based on the context the interviewer should ask when the informant last had sex, rather than if she/he had ever had sex. Most young people are eager to talk about such issues, if given a safe context to do so. The interviewers were well trained, non-judgemental, and non-threatening. They included both men and women of various ages, ethnic background, language, and education.

The interviews were conducted at the convenience of the informant and in an appropriate setting where the informants' comfort, privacy and anonymity were assured. For instance, interview locations included a secluded public space such as a bench on an isolated

area of school grounds, an empty classroom, an empty corner of a café, or in a private home. FGDs took place at the PSI offices (in a private, covered outdoor venue), in school-rooms, and in other public spaces such as clubs and gymnasiums. Because of the size of the group, additional time was required in preparation of the activity to screen each of the FGD participants and gain their consent to participate. Snacks and refreshments were provided. Many FGDs took place at PSI's offices where a quiet meeting space facilitated the recording of the FGDs. To complement the tape recordings, field notes were taken by the interviewers and also considered the primary data. The interviewers were trained extensively in note-taking methods during the training workshop, details of which are discussed at greater length in the section to follow.

Informed consent was gained prior to the initiation of the interview. The consent form was given to the informant and read out loud by the interviewer in the informant's language of choice. The informed consent included a statement of ethics, the objectives of the interview, and the informant's right to refuse to participate or stop the interview at any time. Interviewers were instructed to avoid topics implicating the respondent or others in any criminal activity. However, should such information arise in the course of an interview, interviewers were given instructions to report the incident to the supervisor immediately after the interview was completed. Since both the reporting framework for ethics review was indeterminate in Mozambique at the time of the study, an agreement was made with the MoH to report such adverse events anonymously to the Office of the National Director of Health. Fortunately, no such incidents arose during the study.

Before proceeding with interview, the informant was required to sign the consent form. All interviews were recorded using hand-held tape recorders. Permission to use a recording device was obtained prior to activating the machine. The recorders were kept out of the way using a microphone with a long extension, and the use of long-play tapes (90 minutes) with an auto-reverse mechanism meant that most interviews could be completed without having to switch the tape. Interviews varied in length from 60 minutes to 120 minutes.

The study employed a method of saturation interviewing which sought to exhaust the themes under investigation, and develop new themes as they emerge. Repeat interviews were undertaken only in a handful of cases. Repeat interviews have many advantages. They offer the potential for creating a deep rapport. The time delay between interviews encourages reflection and allows for verification of the previous interviews. There is also more time to explore topics not covered in the initial interview. At the same time, repeat interviews can lead

to the over-saturation of the interviewee (as opposed to saturating the data). The subsequent interview may be lost to follow-up, leaving the interviewer with a half finished interview. In weighing these considerations, the survey team opted to invest more in the initial interview rather than rely on repeat interviews. Initially this proved challenging as the interviews proved long and burdensome for both parties. However, as the interviewers gained experience, confidence and understanding of the interview process, the interviews became more efficient. The iterative process of analysis also contributed to this efficiency. Finally, triangulation facilitated the process of saturation and played an important role in the verification process. This technique compares data gleaned from various sources and methods to ensure the topics explored are consistent across interview types (Bernard 1995).

## 4.3 Data management and analysis

The data management and analysis strategy adopted by the research study had to satisfy several competing objectives. First, the approach could not be so rigid as to constrain the scope of the study. At the same time, the approach required a systematic method to ensure efficiency, fidelity, and transparency. The study relied on an iterative analysis process whereby the moderator guides were adjusted throughout the length of the study to confirm information garnered in previous interviews while exploring new themes as they arose. This method of saturation interviewing required a constant analysis of the data as the interviews were completed.

The methods employed in the research study borrow heavily from grounded theory, which incorporates an iterative process of data collection, analysis, theory building, and instrument refinement (Strauss and Corbin 1998). The approach was exploratory and sought to describe complex processes around the context of risk practice by young people. In the next section, I present the data management cycle, highlighting the iterative process of data collection, analysis and confirmation. Then I describe the coding techniques used to generate meaning from the data.

### *4.3.1 The data management cycle*

Data management was an initial concern, especially given the time constraints of the Project. If a true verification cycle were to be incorporated into the data collection and analysis flow, the process of data management had to be quick and efficient without losing content or context. Of particular concern was the delay in transcribing the interview tapes. Even under the best of circumstances one hour of taped transcript was the equivalent to approximately five

hours of typed transcription. Quality of the tape, ambient noise, and other distractions meant the transcription rate exceeded seven hours per hour of recorded material.

The solution proposed was to treat each stage of the data collection process as primary material. The first data collection stage was the interviewers' field notes. Upon returning from an interview, each RA was debriefed by a supervisor and the field notes were transcribed on the spot with the aid of a data entry clerk. An "annotated" text file was created on the computer and consisted of the primary data along with annotations added during the debriefing. The primary data consisted of the subject's responses (as told by the RA), while the annotations consisted of the debriefed material, thematic coding, comments, and clarifications. It was here that the interviewer could add contextual information not captured on the transcriptions such as non-verbal cues, exclamations, emotions, gestures, and the interviewers' own perceptions of the quality and meaning of the interview. This latter information was attributed to the intervewer and not the interviewee.

The annotation process was the first line of analysis conducted on the material. The annotations were assigned thematic codes, and compared to annotations collected from other interviews. The purpose of this first layer of coding was to look for inconsistencies as well as commonalities in the data. In a repeat interview, the RA might return to the informant to clarify an issue or to explore new issues arising from the analysis. The same applied to new interviews. The process of debriefing enabled the research team to address shortcomings in the interview process as well as to develop new hypotheses about the phenomena they were recording. This process continued until topics were saturated and new lines of inquiry developed.

The role of the supervisors during this process was that of facilitation, critical analysis, and review. Each interview was subjected to careful review. The recording was played through several times, and checked against the annotations. Once the transcriptions of the interviews were completed, the same process was repeated. At various points in the data collection process, the supervisors conducted thematic audits. The thematic codes identified in the annotations were further refined by the supervisors, and the data placed into thematic summary tables. The summaries were then vetted with key informants, especially young people who shared the same language and perspective as the respondents. This audit process helped to validate the results but also generate new interpretations of the data.

Field notes and initial reports were written in Portuguese, thus increasing the immediate utility of the exercise for programme development. Several recordings were wholly or partially

spoken in local languages, mostly Shangaan and Rhonga, although none was conducted exclusively in a local language. Most commonly, local words and phrases would be woven into the conversation, or sections of the interview would shift into local language. As such, the need for full translation was limited. Instead local language and youth dialect (a syncretic mix of local languages, Portuguese, and some English) were translated as the RA took down field notes and confirmed among the study team during the debriefing. The full transcripts were translated into Portuguese as required, and then verified by an independent source. Finally, the field-note annotations and the tape transcripts were compared for inconsistencies and conflicts.

### *4.3.2 Data coding and analysis*

Qualitative data analysis consists of identifying, coding, and categorising patterns found in the data. The process of reducing qualitative data to manageable units is called thematic analysis (Aronson 1994; Boyatzis 1998). Qualitative inquiry generates an enormous amount of data. The source of these data includes interview transcripts, field notes, and observations which must be pared down to manageable units. These units are derived from patterns found in the narrative text including the conversation itself, the use of language therein, and non-verbal cues such as emotions, gestures and implied meanings (Taylor and Bogdan 1984).

How to analyse narrative data depends greatly on the researcher (Spradley 1979; Taylor and Bogdan 1984). Each researcher approaches this task differently, as each qualitative study presents its own set of challenges. The researcher must determine different strategies or criteria to describe the data. The strategy must be well documented, and communicated to the research staff participating in the coding and analysis process. The strategy must also contain a process of verification during the data collection cycle and after. Thematic analysis provides both the lens as well as mechanics for dealing with such large volumes of information.

From the transcribed conversations, identifiable themes and patterns of experiences were listed as the first step. This took place during the initial debriefing of an interview or FGD immediately after it was completed and the interviewer(s) returned to the research office. Analysis was an integral part of the data management process and documented in the section immediately preceding this one. Next, the data were sorted into already classified patterns based on the topical interview guide and the research questions put forth in the objectives of the study. The basic units consisted of direct quotes, but paraphrasing and the observations of the researcher were also considered valid data. Themes were organised by category of respondent,

based on gender, school attendance, sexual activity, and condom use.[41] A list of the themes and codes are presented in Annex 11.8, and the fully developed narrative themes in Chapters 6 to 8.

The next stage was to create sub-themes by combining and cataloguing related patterns. As the themes started to take shape, a story began to emerge that represented the experience observed. The research team undertook group analysis of the themes on a daily and weekly basis, to direct the continued collection of the data, as well as to serve as a verification tool to keep the activity on track. The meetings addressed problems arising out of the data collection process as well as to identify ambiguities and gaps in the study. Also, the group meetings served as a sounding board to develop and validate important narrative lines pursued by the study.

Two breaks to conduct analysis were taken over the course of the study, with the first coming at the midway point in the activity and the second at the end of the data-collection phase. The first break served as a reflection period and to give the study team a break from fieldwork. Major themes identified to that point were consolidated, verified, and sub-themes developed. The narratives were debated and deconstructed. Finally, solutions to difficulties encountered in the field were addressed and solutions proposed. The second break functioned as an analysis workshop. At that point, the narratives were well developed and the team sought to verify them against the then well-established themes and sub-themes. The triangulation of complementary sources of data, both internal and external to the study, helped to build the verification process. External validation came from the use of contextual information and the applicable literature.

By the end of the analysis workshop, the theme structure was well developed and documented. A collective narrative had emerged of the situation of young people and sexual risk. This process and collective narrative was documented in the report prepared for the Project (Karlyn and Mussa 2000), and forms the basis for the analysis presented in this thesis. The theoretical framework and further analysis presented in the rest of this thesis is an extension of these basic results.

Continued text analysis was undertaken subsequent to the completion of the fieldwork. The themes and categories identified in the data were elaborated further, and confirmed against

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[41] The data analysis process was facilitated by a number of computer software. Theme development, coding, hyper searching and text retrieval was carried out using DTSearch© v.6.03. Demographic data of the survey participants were entered into a database using EPI-Info© v.6 and analysed with SPSS© v.11.

both the raw data found in the transcripts, as well as the layers of analysis applied to the primary data. The larger themes and narratives extrapolated from the data reflect specific themes taken up in the latter research stages during FGDs and *fogo cruzado* activities. While the basis of the narratives comes from the SSI, the elaboration of the themes was accomplished using the dramatisations and group interactions of the focus groups. The interpretation of these narratives is my own and reflects the culmination of the process of qualitative inquiry.

### *4.3.3 Semi-structured interview guide*

The semi-structured interview (SSI) instrument used in the data collection for this thesis underwent a series of changes from pre-test (SSI v1) to final iteration (SSI v6) over the course of the study. The process of instrument adaptation mirrored the methods set forth in the saturation method described earlier in this chapter. The saturation method refers to the process of exploring lines of inquiry (in the form of themes and categories) until they fail to yield new or additional results, after which new themes are raised (Baker, Wuest and Stern 1992; Strauss and Corbin 1998). A summary of each version of the questionnaire is presented in Annex 11.5.1, and followed by the English translation of the last SSI instrument (v6) Annex 11.5.2. Table 4 presents the changes in the SSI instrument and corresponding versions and dates:

***Table 4: SSI implementation by version, date, and interview number***

| Version | Start Date | End Date | Corresponding Interviews | Total |
|---|---|---|---|---|
| 1 | 1 March 2000 | 16 March 2000 | Pre-test MI1-A, CAD1-A, AUR1-A, BIL1-A* | 4 |
| 2 | 17 March 2000 | 24 March 2000 | 201, 202, 203, 301, 302, 303, 401, 402, 403 | 9 |
| 3 | 17 March 2000 | 24 March 2000 | 101, 102, 103, 204, 304, 404 | 6 |
| 4 | 25 March 2000 | 30 March 2000 | 104, 105, 305, 306, 405, 406, 407, 501 | 8 |
| 5 | 31 March 2000 | 18 April 2000 | 106, 107, 108, 205, 206, 207, 208, 209, 307, 308, 309, 408, 409, 410, 411, 502, 601 | 17 |
| 6 | 19 April 2000 | 9 May 2000 | 109, 110, 111, 112, 113, 114, 115, 116, 117, 210, 211, 212, 213, 214, 215, 216, 217, 218, 310, 311, 312, 313, 314, 315, 316, 317, 318, 412, 413, 414, 415, 416, 417, 418 | 34 |
| * Not included in analysis | | | | 74 |

SSI version 1 (SSI v1) of the questionnaire was developed using topical guides and codes provided in Ingham, Jaramazovic, Stevens, *et al.* (1996). These materials were chosen because they were developed to examine relationships over the course of sexual life histories as well as in the context of the dyad. While the study did not seek to include partners in the

analysis due to both ethical (ensuring anonymity and privacy) and logistical reasons, the materials were based on the interactional competence model, thus focusing on individual and familial factors contributing to sexual histories, and cognizant of partner interactions as perceived by the respondent.

SSI v1 went through a series of adaptations during an intensive training workshop at the beginning of the study. The workshop participants refined the instrument by adapting the themes, terms, and codes provided in SSI v1 to the language and culture of young people in Maputo (see Annex 11.8.1). At the end of the workshop, the questionnaire was finalized and subsequently pre-tested in a series of individual interviews not included in the final analysis of the study.

SSI v1, like each subsequent iteration, was divided into major sections: 1) preliminary socio-demographic data, 2) youth and family life, 3) social life as an adolescent, 4) sexual development, 5) sexual development over the years. 6) last sexual experience and contrast with last year, and 7) the future.

Section 1, preliminary socio-demographic, established the respondent's name, age, sex, relationships, marital status, partnerships, children, parents, siblings, occupation, origin, education, income, residence, relative wealth, religion, ethnicity, and political participation. Section 2, youth and family life, focused on the family environment, life at home, rules of the house, caring, mutual assistance, and resolution of conflicts. Household communication about sex was asked as well as early perceptions of sexuality and non-consensual sexual contact. Section 3 explored the respondent's social life as an adolescent including formative experiences, friendships, schooling, social life, general well-being, and state of physical and emotional health. Section 4, sexual development, established the respondent's first sexual feelings, first experiences courting, and first sexual intercourse. Section 5 established the individual's sexual development over the years and covered themes such as one's sexual history, knowledge about contraception, masturbation, commercial sex, sexual violence, and an opportunity to reflect over this sexual career. Section 6 established specific events around one's last sexual experience as well as sexual experiences in the past year. This section focused on sexual interactions, partner communication, protective practices, and an overall evaluation of one's sexual life. Finally, Section 7 offered the respondent an opportunity to express his or her ideal future both in terms of sex, relationships, aspirations, and risks.

SSI v2 (17-24 March) attempted to redress two of the principal difficulties interviewers experienced during the pre-test. First, the structure and format of the questions were too closed for the interviewers to easily adapt to the specific context posed by each respondent. The table structure of the questionnaire forced the interviewer to continually interact with the guide both in terms of following the flow of the questions and subsequently to record data on the questionnaire. As a result, the interviewer was forced to write interviewer responses on both the SSI guide and his or her field notebook. Feedback from the pre-test indicated that a topical guide format rather than closed questions would allow for a more flexible approach.

SSI v2 reorganised the themes found in the first version. The contrast between 'Case 1: First sexual experience' (Section 4) and 'Case 2: Contrast with past year' (Section 5) were juxtaposed to facilitate focus on specific sexual events. Further changes to the content include investigating specific actions related to protective practices by partner type, including the use of condoms to prevent pregnancy and STDs, and HIV/AIDS.

SSI v3 (17-24 March) was used concurrently with SSI v2 in order to test whether format was having any impact on the results collected. While the content of the two versions coincided closely, the format of SSI v3 was changed back to a table structure similar to SSI v1. However, the length of SSI v3 increased dramatically, making it unwieldy. Questions were added to SSI v3 in Section 4.3, Sexual practices and prohibitions, and Section 5.6, Sexual pressure and coercion.

SSI v4 (25-30 March) resolved the formatting issue by combining an outline structure with a simplified table structure to present the various themes. This eliminated the tendency to record information both on the questionnaire and the field notebooks used by the interviewer. The content of SSI v4 changed slightly as well. Section 7 on Safe Sex was added to explore respondent views on HIV/AIDS prevention, perceived risk of HIV/AIDS, condom use, and exposure to the *Jeito* social marketing campaign.

SSI v5 (31 March - 18 April) is nearly identical to the previous iteration, with the negotiation of risks highlighted as an area of more intense investigation. It was noted however that the interviews were taking quite long (2-3 hours on average) and the interviewers were struggling to cover all of the themes required. In addition, the respondents were becoming fatigued and in several cases an interview had to be stopped and then continued at another time, running the risk of the interview being lost to follow up.

Finally, SSI v6 (19 April – 9 May) represents a re-orientation of the guide with the objective of simplifying and streamlining the interview process. The interviewers had at that point completed a minimum of 10 interviews each using previous protocols. It was decided by the study team that a non-question based guide would be most efficient. Firstly it gave the interviewer greater flexibility in formulating the questions as appropriate to the respondent, flow of the interview, style of communication, and nature of inquiry as an inductive conversation. Secondly, the elimination of the table structure reduced the length of the guide dramatically, from 19 pages to 6 pages. This proved to be much less imposing to the respondent and more easily handled by the interviewer.

The content of SSI v6 mirrors that of SSI v4-5, however interviewers were instructed to probe more deeply on issues of social networks, intergenerational communications, definitions of partner types, identities associated with different partner types, perceptions of promotional campaigns, and sexual pressure, coercion, and violence.

### *4.3.4 Focus group guide*

The focus group discussions differed from the SSI in both style and content, however considerable overlap did exist in order to ensure adequate confirmation of themes and results. Instead of exploring individual information, the FGD explored the language, values, and meanings that arise in conversations among young people. A narrative technique was used to systematically identify the dominant themes of sexual discourse among young people, including sexual behaviour and relationship types, as well as their social implications.

The narratives consisted of scenarios taken from the *fogo cruzado* (see Annex 11.9.1), however the full *fogo cruzado* intervention was not implemented as part of the study design. These scenarios allowed for nuanced expression of sexual meanings not always available to young people's discourse or their own sexuality. In addition to the *fogo cruzado* scenarios, additional scenarios were developed throughout the course of the individual and group interviews. These were labelled the *"fogo focal"* scenarios (see Annex 11.9.2) since they combined elements of the *fogo cruzado* with focus group methods. Since these modified scenarios were developed over the course of the study, their introduction was limited to FGD v4.

Four revisions of the focus group discussion (FGD) guide were elaborated over the course of the study, however only the last iteration, v4 is present in Annex 11.5.3. As summary of the implementation of each guide is provided in Table 5. Prior to the implementation of the

FGDs, respondents were administered an informed consent form. Upon accepting to participate in the study, an assisted-administered screening questionnaire was given to each FGD participant in order to establish their individual socio-demographic profile prior to the initiation of the discussion (see Annex 11.5.4).

***Table 5: FGD Implementation by version, date, and interview number***

| Ver | Start | End | Corresponding Interviews | Total |
|---|---|---|---|---|
| 1 | 06-Apr | 14-Apr | 702, 801, 802 | 3 |
| 2 | 17-Apr | 20-Apr | 705, 706, 707, 803 | 4 |
| 3 | 24-Apr | 25-Apr | 704, 708, 709, 804, 805 | 5 |
| 4 | 25-Apr | 08-May | 710, 711, 712, 713, 714, 715, 806, 807, 901, 902 | 10 |
| | | | Total | 22 |

FGD v1 is divided into 11 sections and explores 1) how young people talk about sex, 2) the pressure felt by young people around issues of sex, sexuality, and sexual violence; 3) the associated risks sexual relationships bring and how risk is negotiated; 4) condom use to mitigate risk; 5) information about HIV/AIDS, including its aetiology, origin, transmission, and impact the lives of young people; 6) safe sex practices and their promotion through social mobilisation campaigns; 7) sexual norms, practices, prohibitions, and the relationships therein; 8) pregnancy and childbirth; 9) commercial sex; 10) social networks; and, 11) commercial/transactional sex.

Versions 1-3 of the FGD guide start with questions related to the interpretations of the *fogo cruzado* narratives. However, the narrative techniques were not implemented until FGD v4 of the guide for two reasons: first, as mentioned above, the themes to be used for the narrative were developed using the SSI interviews and initial FGD discussions; and second, logistical delays in developing and refining the narrative method precluded their earlier use. By FGD v4 of the guide, the narrative technique had been perfected and thus implemented in 8 of the 10 remaining FGDs. The two exceptions, FGD#710 and FGD#806, did not use the narrative technique due to restrictions associated with the location where the discussion took place.

FGD v2 attempted to reduce the number of topics explored in order to reduce the overall time of the FGD. Section 3 on gender differences was dropped from the first version and integrated into other sections of FGD v2. Likewise, the specific issue of date rape was taken out and replaced with a wider investigation on sexual coercion and violence in FGD v2. Also reorganized in FGD v2 are issues of relationship initiation and formation, partner type, safe sex, the meaning of sex, pregnancy and childbirth, and social networks. While investigation of these issues continued throughout the remaining versions of the guides, they

were seen as cross-cutting issues that each topic should address rather than separate issues to be discussed. FGD v2 added questions about partner communication in Section 1, a comparison of risk perceptions between men and women (Section 3), and the difference between HIV and AIDS (Section 6).

FGD v3 reflects a simplification of the guide format from structured questions to statement formats. This approach mirrors the same transition of the SSI between Versions 1 to 2, and Versions 5 to 6. The format change allowed the moderator greater flexibility in formulating questions and exploring themes. For instance, in Section 2 moderators were instructed to explore inter-partner communication around issues of sexuality and protective practices. In Section 4, risk and responsibility was reframed to focus more on the costs and benefits of various risk mitigation practices. The discussion of condoms in Section 6 focused the discussion on how condoms were perceived and used by partner type. In Section 10, the guide simplifies the discussion around sexual practices and prohibitions, recognizing the limitations of young people's knowledge of traditional practices.[42] Section 11 on commercial sex attempted to explore the transactional nature of relationships including intergenerational (sugar daddy) relationships, rather than focus solely on formal commercial sex. Finally, FGD v4 of the guide is virtually the same as the previous version with the exception of the inclusion of the *fogo cruzado* and *fogo focal* narrative technique.

### *4.3.5 Data Organisation and Analysis*

The analysis presented in the thesis follows three distinct phases. Phase 1 was primarily organisational in which the interviews were categorised using the sampling matrix provided in Graphic 10. Phase 2 organised the interviews into comparative themes based on field notes and summaries. Phase 3 was a more directed in-depth analysis of the interviews using content analysis to identify discourses around specific social/sexual identities identified in the first two stages. Before describing each stage of data analysis in more detail, I will first describe the management of the interview data.

### *4.3.6 The data management process*

The data from both the SSIs and FGDs were divided into three types of text files annotations, summaries, and transcripts. The annotations are the interviewer fieldnotes which include direct quotes from the respondents, the interviewer observations, and supervisor

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[42] Although this topic was extensively covered in SSIs, the fact that young people have limited information regarding 'traditional' knowledge of sex, sexuality, and fertility regulation warranted some discussion of the topic.

comments.[43] The summaries are individual interviews summarised by section of the interview guides. The transcripts were the fully transcribed tapes of the interviews.[44]

The challenge of capturing, organising, and analysing a large quantity of qualitative data in a very compressed time period required the data management process to be quick and efficient. The intervention context of the study was an important limitation in terms of methods and timing. Methods, specifically the narrative techniques used in the FGDs, were dependent on the cooperation of two Project staff highly trained group moderators, but only dedicated to the study half time. Timing was limited because the Project had allocated resources for the study for a period of 3 months. Instead of waiting for the audio tapes to be transcribed, I used the interviewer's fieldnotes (the annotations) to track the progress of the study, organise the interviews into meaningful categories, and identify gaps in the study in terms of categories of individuals interviewed and themes covered.

In order to ensure the quality of the annotated interviews, each interviewer was extensively trained in note-taking techniques and shorthand codes to assist in the capturing of the interviewers own words. Immediately after each interview, I personally debriefed each interviewer and then accompanied the typing up of the interview. Additional comments and observations based on the debriefing were added to the annotation file. My role as research supervisor during this process was to facilitate, provide critical analysis, and review. Each interview was subjected to careful review. The audio recording was played through several times, and checked against the annotations. Once the transcriptions of the interviews were completed, the same process was repeated. The audio tape transcriptions were undertaken during the course of the study, however the priority was given to transcribing field notes and summaries. The process of transcribing the audio tapes continued past the end of the field phase of the study, however the Project no longer supported all three typists to continue the transcriptions. Instead, I hired one typist to complete the transcriptions out of normal working hours. This ensured the security and confidentiality of the audio tapes, however it added considerable time to the completion of the activity. I received the fully typed transcripts in September 2000.

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[43] The term annotation was used because in Portuguese it means to make note or observe. It does not directly translate to the English meaning of adding a note or comment.

[44] A more in-depth explanation of the process is given in Section 3.3.1 on page 99 of the thesis.

### *4.3.7 The data analysis process*

Phase 1

Phase 1 of the analysis dealt only with annotation files containing interviewer fieldnotes. The annotations were organised into categories based on the original sampling plan, the interview guide, and emerging themes collected from other interviews. These categories include age gender, school attendance, partner type, sexual activity, and condom use (see Annex 11.8.2). This preliminary organisation of the data were based on the topical guide and codebook provided by Ingham, Jaramazovic, Stevens, *et al.* (1996).[45] The data were organized through a visual matrix using a wall chart of key socio-demographic and thematic data and was updated daily to track the data collection progress and results.

Phase 2

Phase 2 organised the interviews into comparative themes based on the interview summaries and annotation files.[46] The analysis was conducted with the assistance of the research team upon the completion of the data collection and provided to PSI as a final deliverable of the activity (Karlyn and Mussa 2000). Themes were identified and organised into summary tables based on a method provided by Boyatzis (1998).

The objective of the analysis was to provide a comprehensive comparison of the data across categories and themes. The results of this analysis are documented in Chapter 5 of the thesis as a comprehensive description of the study participants in terms of socio-demographics, sexual activity, sexual partners, condom use, and other protective practices. These descriptive data were largely derived from the SSIs, the FGD participant screening questionnaire, and the FGDs. The latter provided the contextual information used to describe the context and meaning of sexual behaviour by partner type, condom use, and risk mitigation strategies.

Phase 2 of the analysis was divided into three steps (see Annex 11.8.3). Step 1 was to summarise each individual and group interview into a summary matrix organised by categories

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[45] The topical guide and codebook provided by Ingham, Jaramazovic, Stevens, *et al.*(1996) greatly informed the design of my instruments. Naturally, the categories and themes taken from these sources was instrumental in assisting me to think about the interview data collected, how the data should be organised, and which emergent themes from the data were most salient. I did not, however, attempt to code the data using the codebook since this was the very first phase of the analysis and increasingly it became clear that the original purpose of the codebook was to ensure inter-coder reliability across multiple country interview datasets. My study did not have these requirements.

[46] The typed transcripts of the audio tapes were not yet available during Phase 2 of the analysis, however the original audio tapes were consulted.

derived from the interview data. Step 2 was to summarize the interview summaries across themes which emerged from the interview data. Step 3 then re-categorised the summary results by socio-demographic and behavioural categories. The purpose of re-categorising the results was to develop risk profiles for the Project. Summary reports were written based on this aggregated data and presented as the final project report for the activity (Karlyn and Mussa 2000).

Phase 3

Phase 3 of the analysis took place after the end of the fieldwork and was conducted independently from the *Jeito* Project. Phase 3 used each type of data, including the annotations, summaries, and full transcripts of the audio data. As previously mentioned, the fully typed transcripts became available approximately three months after the end of the data collection activity in September 2000.

Phase 3 followed a more nuanced thematic analysis approach than previous phases. Since Phase 2 provided a comprehensive comparison and contrast of the data, Phase 3 sought to develop theories as to why interventions failed to reach their intended target population and in turn why young people largely failed to act upon the prevention resources at their disposal. Phase 3 applied ethnographic content analysis to identify discourses around specific social/sexual identities found in the previous analysis phases (Pelto and Pelto 1978; Spradley 1979; Scrimshaw, Carballo, Ramos et al. 1991; Pool 1997).

Specifically, the analysis focussed in on two sexual identities, the "survivor" and the "*saca cena*", which are the subjects of Chapters 7 and 8 of the thesis. The analysis honed in on sexual identities as the key intervening modality in explaining young people's sexual risk taking. I sought to understand how gender and power relations define and control sexual identity and determine sexual choices among young people. Furthermore, I sought to understand how and why some young people come to terms with risk and adopt innovative sexual behaviour including condom use.

Annex 11.8.4 demonstrates the process of identifying the underlying constructs leading to identity formation and the sexual practices associated with partner type. Annex 11.8.5 demonstrates how the analysis then deconstructed the elements of risk associated with different partner types. The themes used include the key constructs of identity, appearance, and the social construction of risk. These were identified as important mutable characteristics associated with the use of prevention practices. The analysis in Annex 11.8.6 looks at a specific

case study of two potential outcomes of sex for young people, either first sex (the right side of the diagram) or unwanted pregnancy (left side). The analysis looked both at young women and young men to understand the meaning and construction of each potential outcome. Lastly, Annex 11.8.7 demonstrates the potential outcomes used in the narrative analysis to test young peoples' perceptions of the context of risk.

To carry out Phase 3 of the analysis, DTSearch hypertext search software, one of many computer aided search and analysis software on the market, was used. DTSearch was selected for its speed, flexibility, and ability to locate specific text strings within a large series of documents. The capacity to extract the text surrounding the search strings proved to be an important advantage offered by the software.[47] The text output from a search is then extracted and interpreted through content and discourse analysis.[48] More complex searches are also possible with DTSearch.[49] A set of interview files can be selected and then compared. This would be similar to doing a cross-tabulation with quantitative data. This technique of comparing and contrasting data elements contributed greatly to the process of theory building., allowing for a flexible and comprehensive exploration of the data while providing an audit trail of search results.

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[47] See Silverman (2000:171) who warns that "decontextualization of data ... can occur in simple code-and-retrieve approaches".

[48] The full text output from this search is not included here because of length of the output (13 pages). However, text output from the searches used in the Phase 3 analysis are available upon request.

[49] More complex techniques tend to yield more precise searches since typos, spelling errors, garbled text, and other sources of noise can mask results. However, DTSearch has facilities for fuzzy (sounds like) searches, wildcard characters, and concatenations.

# 5 RESULTS: PERCEPTIONS OF RISK AND CHANGE

This chapter presents basic data on the sexual behaviour of young people in Maputo and is organised in two sections. The first section provides a socio-demographic profile of the study participants and then charts major trends in youth sexual practice including sexual initiation, sexual activity in the past year, and condom use with various partner types. The respondent profile provides a brief overview of the socio-demographic characteristics of the participants as well as trends in sexual behaviour, demographics (age, school attainment, residency, mobility, employment and household size), and self-reported sexual activity, disaggregated into current and past relationships, relationship duration, and children. Sexual activity is examined next, including the number and type of sexual partners. The first section of the chapter concludes with data on condom use in different sexual encounters (both last and first) as well as ever use and consistent use.

The second section of the chapter explores the context that drives sexual behaviour based on perceptions of risk and sexual meaning adopted by young people over their sexual career. This section highlights the common characteristics, differences, and larger trends found among cohorts. Several crosscutting themes are highlighted by the results and provide the basis for further discussion. Reflection by informants on major life events uncovered patterns of social interaction including sexual experiences, serious relationships, school attainment, and sexual violence. These contexts were explored over the sexual careers of the individuals interviewed from earliest feelings of sensuality, first sexual intercourse, and different partners over the course of their sexual career. This line of investigation resulted in a detailed discussion of their last sexual relationship, along with any concurrent sexual partners the respondent might have. The contexts of sexual relationships also formed the basis for a subsequent discussion of perceptions of sexual risk including unwanted pregnancy, modes of prevention, condom use, partner types, and sexual pressure.

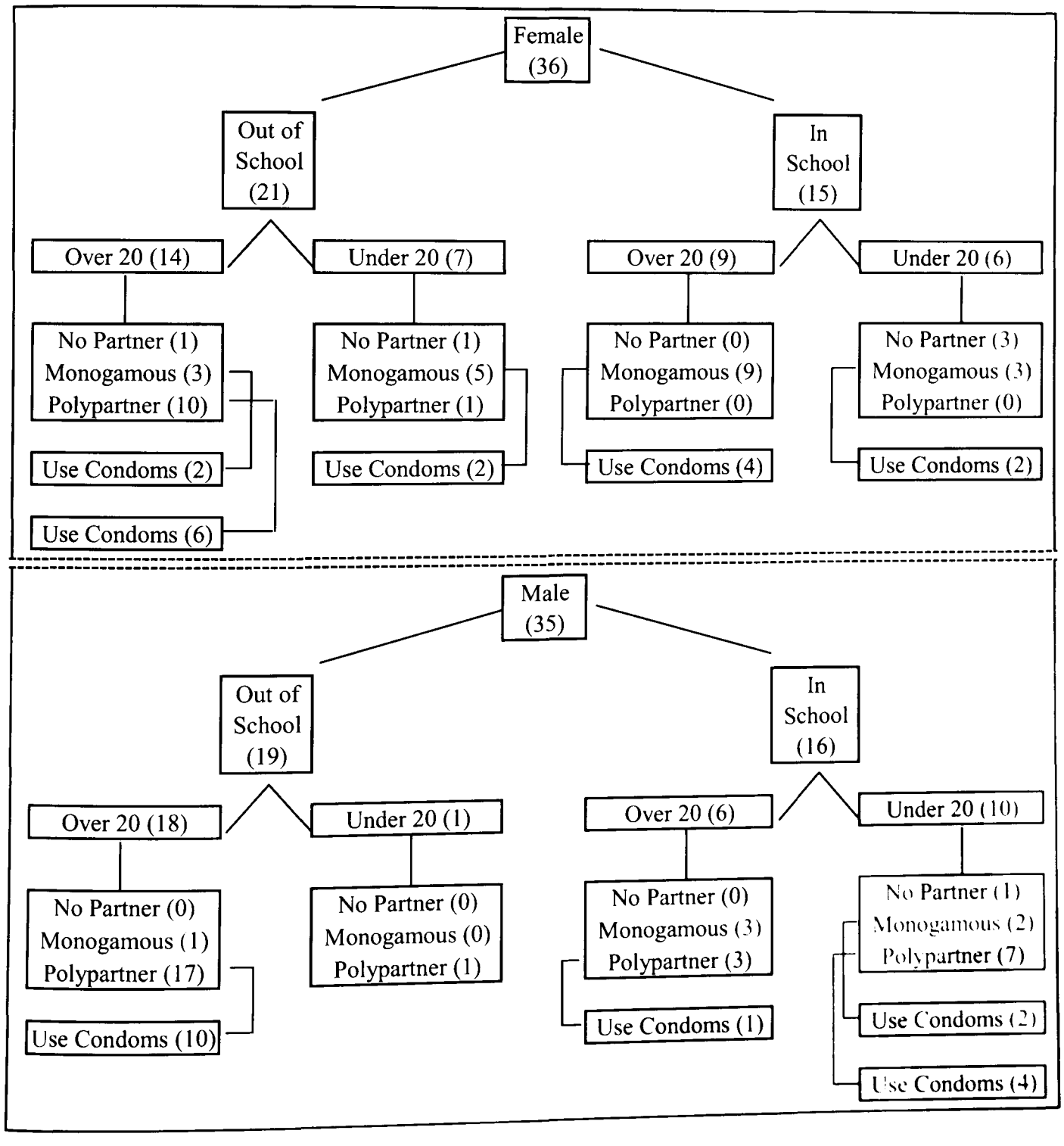
Before considering the respondent profile, a caveat should be given regarding generalisation based on qualitative data. As with all data collected with purposive sampling, the data presented below are not representative of all young people in Maputo. I provide them for the reader to have a sense of who participated in the study and discourage generalising these data to the population as a whole.

The data were collected using screening questionnaires before participation in the FGD. For SSIs, the data were obtained from the transcripts, but asked in the same manner. This is the only section in which FGD participants are disaggregated from their group as a whole.

## 5.1 Respondent Profile

While the sampling plan called for a balanced distribution of selection categories, the nature of the inquiry directed the sample toward what was considered the most interesting and illustrative cases. As demonstrated in Graphic 12, the study disaggregated individuals by partner type and condom use. Although not represented in the graphic, the non-use of condoms was just as important in many cases as their use.

***Graphic 12: SSIs by sex, school, age, partner type, and condom use***



In part, this distribution reflects the demographic and risk practices of young people in Maputo. For instance, in both cohorts of women and men out of school, fewer under 20's were interviewed. For the in school youth, the situation was quite different. Fewer men over 20 were found in school while fewer women under 20 were interviewed. This may reflect the enormous pressure to stay in school felt by young women who make it through the school system to the secondary level.

### *5.1.1 Profile*

In all, 300 young people participated in the study through either SSIs or as part of a FGD. A total of 71 SSIs were undertaken, 36 conducted with women and 35 with men. Of the 36 interviews conducted with women, 17 were undertaken among secondary school students with the remainder not in school either due to dropout or course completion. Among the male interviews, 17 were undertaken among students and the remaining 19 were out of school (see Table 6).

***Table 6: Sample distribution***

| | <20 years old | | 20+ years old | | Total |
|---|---|---|---|---|---|
| | In School | Out of School | In School | Out of School | |
| **Men** | 33 | 15 | 42 | 43 | 133 |
| | 11.0% | 5.0% | 14.0% | 14.3% | 44.3% |
| **Women** | 61 | 16 | 37 | 53 | 167 |
| | 20.3% | 5.3% | 12.3% | 17.7% | 55.6% |
| **total** | 94 | 31 | 79 | 96 | 300 |
| | 31.3% | 10.3% | 26.3% | 32.0% | 100% |

The FGDs consisted of 22 groups consisting of 226 participants, with an average of 11 participants per group. While not all groups were homogenous by gender, 12 groups were exclusively female, 8 groups male, and two purposively mixed. Most FGD participants were in school at the time of the interview, with 62% reporting to be currently matriculated in either day classes or night school.

The average age of the study respondents was 21 years (see Table 7). Just over half (58%) of all the study participants were enrolled in school at the time of the study. As a whole, the study population had an average of 8 years schooling, corresponding to the initial year of secondary education in the Mozambican system. For the older cohort, women out of school had two less years of schooling on average than men (7 versus 9) while the opposite was found for those in school where women averaged 2 more years of class attainment than their male counterparts (10 versus 8). Some respondents attended private secondary schools, both secular

and non-secular. The vast majority, however, attended state-run schools in Maputo or Matola City, a satellite community to the west of Maputo City.

***Table 7: Socio-demographic distribution of the sample***

| | |
|---|---|
| Sexually Active | 77% |
| Current Sexual Relationship | 73% |
| Other Sexual Partner | 23% |
| Duration of Current Relationship (months) | 16.7 |
| < 1 Month | 24% |
| 1 Year or less | 45% |
| + 1 Year | 32% |
| Number of Lifetime Sexual Partners | 2.3 |
| <1 | 48% |
| 1 | 22% |
| 2 to 3 | 21% |
| 3 or more | 9% |
| Number with Children | 17% |
| Used Condom During Last Sexual Encounter | 53% |
| Consistent Condom Use | 19% |
| Used Condom at First Sexual Encounter | 11% |
| Last Sex with Casual Partner | 8% |
| Gave/Received Money for Sex | 8% |
| N=300 | |

On average, the study participants lived in Maputo for 17 years, roughly corresponding to their ages. However, women out of school over 20 years old reported an average of 15 years resident in Maputo, considerably less than other participants. Just over one fifth (21%) of participants had lived outside of Maputo at some point in the year prior to the study. Older women out of school again registered higher indices of mobility, with 29% having lived outside of the city while 43% of younger men out of school reported a distant residence in the past year. Generally, those out of school were more mobile than those in school. Respondent household composition averaged 6 family members per household and ranged from 1 to 15 members. A quarter of respondents was employed either formally or informally (as defined by earning cash remuneration). Men were more likely than women to be employed (35% versus 17%). Over half (54%) of older men out of school worked. At the other extreme, only 4% of younger women in school worked.

### 5.1.2 *Sexual activity*

Most respondents (77%) were sexually active and reported a high frequency of condom use (see Table 8). Most notable is the stark contrast between men belonging to the older cohort. Among those out of school, 93% reported to be sexually active, compared to 54% of those in school. The contrary was found among younger women, whereby 68% out of school reported to be sexually active compared with 92% of those in school.

***Table 8: Sexual behaviour and condom use***

| | Age of Respondents | Mean Number of Years of School Attainment | Sexually Active | Current Sexual Relationship | Mean Duration of Current Relationship (months) | Casual Partner | Used Condom During Last Sexual Encounter | Used Condom at First Sexual Encounter | Consistent Condom Use | Children | Gave/Received Money for Sex | Last Sex with Casual Partner | Lifetime Sexual Partners | N | % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ♂ in <20 | 18 | 9 | 85% | 75% | 12 | 43% | 75% | 14% | 32% | 0% | 21% | 11% | 1.8 | 33 | 11% |
| ♀ in <20 | 17 | 9 | 75% | 74% | 19 | 9% | 57% | 24% | 30% | 0% | 0% | 2% | 0.5 | 61 | 20% |
| ♂ in >20 | 22 | 8 | 52% | 82% | 14 | 45% | 69% | 5% | 32% | 18% | 14% | 23% | 2.1 | 42 | 14% |
| ♀ in >20 | 22 | 10 | 92% | 68% | 16 | 9% | 59% | 18% | 21% | 21% | 3% | 3% | 0.5 | 37 | 12% |
| ♂ out <20 | 18 | 7 | 87% | 46% | 24 | 38% | 17% | 0% | 8% | 8% | 0% | 23% | 0.4 | 15 | 5% |
| ♀ out <20 | 18 | 7 | 81% | 69% | 30 | 15% | 44% | 8% | 8% | 23% | 0% | 0% | 0.6 | 16 | 5% |
| ♂ out >20 | 23 | 9 | 93% | 90% | 12 | 40% | 61% | 5% | 10% | 25% | 23% | 10% | 2.9 | 43 | 14% |
| ♀ out >20 | 23 | 7 | 68% | 64% | 19 | 3% | 15% | 3% | 3% | 42% | 0% | 3% | 0.4 | 53 | 18% |
| Total | 21 | 8 | 77% | 73% | 17 | 23% | 53% | 11% | 19% | 17% | 8% | 8% | 1.2 | 300 | 100% |
| N | 300 | 297 | 300 | 232 | 149 | 232 | 182 | 232 | 232 | 232 | 232 | 232 | 183 | 300 | |

in = in-school out = out-of-school

At the time of the interview, 73% were involved in a principal relationship. More men (79%) than women (69%) reported a current relationship, but younger women out of school were more likely to be involved in a relationship than boys of the same age and school status. The average duration of the respondent's current principal relationship was 17 months. This corresponded to 24% of relationships lasting less than one month, 45% from one month to a year, and 32% greater than a year (not shown in table). A similarly large proportion (82%) had been involved in a romantic relationship at some time in the past (not shown in table). Women tended to have longer relationships than men (19 months versus 14 months) and the youngest cohorts out of school registered much longer (about 10 months longer) relationships than any other cohort.

Overall, 82% reported having a past relationship prior to the study, with more men (88%) than women (77%) reporting a past relationship. Again, the youngest cohort out of school reported higher indices of past relationships than other cohorts, with all reporting having had a relationship. Seventeen percent reported one or more children, with women having more than men (19% versus 15%). Older women out of school had the highest percentage of children (42%) while none was registered among both younger cohorts still in school.

### *5.1.3 Sexual partners*

The mean number of lifetime sexual partners reported by the study participants was 1.2 partners. Men registered a greater number of partners than women, with 2.1 average partners for men and 0.5 for women. Over 20 men had the reported a higher mean number of partners (2.9) followed by older men in school (2.1) and younger men in school (1.8).

Only 8%, however, indicated that their last sexual encounter was with a casual partner. T0\his was more common among men (15%) than women (2%). Men were more likely to have a secondary partner besides their principal partner at the time of the survey, with 42% of men and 8% of women reporting a secondary partner. Men over 20 and in school reported the highest frequency, with 45% reported a secondary partner. For women, 15% of the youngest cohort out of school reported a secondary partner.

Far more men (17%) than women (1%) engaged in commercial sex in the past, either as recipients of or clients of sex for money. About a fifth of younger men in school and older men out of school had engaged in commercial sex. Just 3% of women found in the oldest cohort in school reported having sex for money.

### *5.1.4 Condom use*

Roughly half (53%) of all sexually active respondents reported having used a condom in their last sexual encounter. More men (60%) than women (48%) used a condom in their last sexual encounter. Those reporting the lowest usage included younger men out of school and older women out of school. Rates of condom use among those in school were higher than those out of school. The highest usage was found among younger men in school (75%).

At sexual initiation, only 11% used a condom, with more women (15%) than men (7%) reporting to have done so. Nearly a quarter (24%) of younger women in school used a condom their first time, followed by 18% of older women in school. None of the younger men out of school used a condom while few (5%) older men regardless of school attendance used a

condom at initiation. Few women out of school, 8% for those under 20 and only 3% over 20 reported use at initiation.

Many respondents (69%) reported having used a condom at some time in the past. Men had more experience with condoms than women (77% versus 63%). Lower condom use was noted among women out of school. For those over 20, only 22% had ever used a condom while just over half (54%) of those under 20 reported ever using a condom. 92% of men and women under 20 and in school have used a condom. Older men and women in school also reported high usage (71%), but lower than their younger counterparts.

Experience with condoms, however, did not translate into consistent condom use, defined as the insistence on condoms during every penetrative sexual act. Overall, only 19% considered themselves consistent condom users. At best, nearly a third of younger men (32%) and women (30%) in school reported themselves to be consistent users. Older men in school registered the same as their younger counterparts, although older women in school lagged slightly behind (25%). Less than 10% of those out of school used condoms consistently.[50]

## 5.2 Contexts and meanings in youth sexual behaviour

Based on this profile, a picture emerges of youth sexual behaviour in Maputo similar to that of other urban settings (UNAIDS 1998b). Education and age are important factors that influence sexual behaviour and social expectations. The vast majority is sexually active and reports involvement in long-standing sexual relations with a principal partner. Yet a core of individuals, particularly men, report relatively high levels of casual sex, either in addition to their principal partner or because of rapid partner change. Those individuals engaged in casual sex account for roughly a third of men's reported sexual contacts while only about 6% of women engage in casual sex. In addition, risky sexual behaviour pervades regardless of educational level. Condom use is more frequent among men and women with higher educational attainment, nevertheless women overall use condoms less than men.

While many of the identified trends are consistent with what is known about youth sexual behaviour, anomalies persist. For instance, men exhibit high-risk practice while women did not. The average duration of a principal relationship was 17 months, however longer intervals were recorded for the youngest cohorts of men and women. Condom use across

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[50] Consistent condom use is also defined as 75% of encounters using a condom. In this case, respondents were asked if they used a condom every time they had sex with all partners as an indicator not only of protective practices but also the ability to refuse sexual intercourse without a condom.

cohorts was high, with over half reporting their use in their last sexual encounter. Moreover, almost a third of in school youth reported using condoms consistently. Men reported higher condom use than women across categories, except at first intercourse. At the same time, just over a third of men reported having sex with a casual partner while only 7% of women reported the same.

How can we explain this coincidence of high-risk behaviour and protective practices? Men are engaging in casual sex while women appear to employ a 'have-hold' strategy of acquiring a principal boyfriend and investing greatly in keeping him.[51] Demand for high-risk sex would likely correspond to higher demand for condoms. This would explain men's behaviour, but not women's. An alternative explanation is that individuals perceive risk based on partner types. The subsequent terms of a relationship vary depending upon the perceived value that each individual ascribes to it. Sexual practices including condom use are driven directly from this negotiated construct of risk within a relationship.

### *5.2.1 Partner types*

In this section of the chapter, I present the various contexts described by the study participants. The construct of partner type dictates meaning and practice of sexual activity, sexual identity, risk perception, condom use, and life strategies. Sexual practice is taken up from the perspective of risk of unwanted pregnancy and STI/AIDS. Risk is associated with partner type and thus prevention practices follow accordingly in the form of partner selection and condom use. Contexts to be examined include sexual initiation, where coercion plays a key role in determining behaviour. Finally, patterns of sexual practice are put forth as identities of prevention and risk.

Two predominant types of partners were noted in the study. The first type is a principal partner consisting of either a stable boy/girlfriend known as a *namorado/a*, or a marital partner (*esposo/a*) by formal or traditional marriage, or partnership based on mutual commitment and cohabitation. Secondary partners include transient casual relationships such as one-night stands (*saca cena*), or casual sex with a friend or acquaintance (*pita* or *amiguinho/a* – little friend). Lastly, transactional sex takes place either within the bounds of formal prostitution or with a sugar daddy, which is also known as an *HR* for rich man (*homem rico*) or sponsor (*patrocinador*).

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[51] Reiss (1967) describes the 'have-hold' discourse permissive affection because sexual activity only advances with affective investment and future commitment.

> There are different types of partners, there could be *pitos*, *saca cenas*, 'part-times', husbands, lovers, *checa la foi* [the bill is gone], and boyfriend ... [with a boyfriend] you have an exchange of experience, conversation, and have sexual relations. You talk more with a *namorado* about problems, pain, or sex. A *pito* is different from a boyfriend, with him you don't have sexual relations ... it's only kisses and long walks. A *pito* ... knows how to take you out ... to the cinema and that kind of thing – a little here and there.[52]

A marital partner, known as a *marido* (husband) or *mulher/esposa* (woman/spouse), is the most stable of relationships and marked by exclusivity, a high degree of social control, long-term commitment, procreation, and stability/security. A marital relationship severely limits sexual practice to a proscribed set of acts, mostly maximising procreation.

A *namorado/a* is a main or principal boy/girlfriend and indicates a durable relationship of romantic and potentially marital intent. The relationship is considered exclusive, although a pervading attitude of 'boys will be boys' was noted among members of both sexes, indicating some acceptance of non-exclusivity. This category was associated with rigid norms of conduct, especially as related to sexual practices. Certain sexual acts were considered disrespectful if performed with one's *namorado*. There is an expectation the male partner should be older and more experienced while the female partner is younger and less sexually knowledgeable.

Secondary partners include the *saca cena* (one-night stand), *pito/a* (kid), HR (*homem rico* – rich man) and *prostituta* (prostitute). The *saca cena* is a casual partner met at a bar or disco. The context of the relationship is limited to the one interaction and marked by a set of tacit rules of anonymity and sexual experimentation. No commitment or additional expectations are placed on the participants. This partner type will be discussed further in Chapter 8.

The *pito/a* can be a stable secondary partner valued for companionship and affection. A *pito/a* can be a long-term or short-term relationship, but implies little expectation of exclusivity or durability in the relationship. Also, sex with a *pita* allows for experimentation in ways not permissible in a stable relationship.

Another set of secondary partners is transactional in nature, either based on informal exchange or formal sex for money. The HR may be a stable, nonexclusive, transactional sexual relationship based on the exchange of presents and other favours. This is the sugar daddy

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[52] FGD #704A / 16.5 years old / ♀ / 9th class / out of school / sexually active

relationship which is marked by large age differences between the man and women.[53] For the woman, the relationship is status enhancing and allows her to display an image of wealth through trendy clothes, access to a car, a cell-phone, a flat, and nights out at bars, discos and restaurants. The social and economic motivations for youth sexual behaviour have been well documented, both in terms of multiple partnerships as well as serial monogamy. Different motives influence sexual behaviour for women and men. Young women in sub-Saharan Africa suffer enormous pressure to marry early and have children. For others sexual relationships with older men ensure economic support for their studies and/or material goods that contributes to their social status. Young men cite sexual pleasure and the biological need to have many sexual outlets as motivation for having multiple partners (Van Rossem and Meekers 2000). The sugar daddy phenomenon has been widely attributed to declining economic conditions where exchange of sex for material goods is part of an economic survival strategy of young women and their families (Hawkins and Meshesha 1994). A FGD of older women still in school put it succinctly:

> Nobody wants a poor boyfriend. They always want to find someone with means, it could be someone ordinary, but he can't be poor.[54]

A conventional definition of commercial sex as prostitution includes the practice of sex for money, with no emotional involvement on the part of either party. The practice was not considered socially acceptable but a necessity. Prostitution was acknowledged by participants as sex in exchange for material goods or services and widely attributed to poverty and desperation. Dixon-Mueller (1993) however, makes the distinction between transactional sexual exchange and commercial sex. The former is an extension of existing marital/partnership exchange relations while commercial sex varies drastically from temporary economic coping strategies to formalised sex work. Even what may seem as voluntary sexual exchange may be driven by economic necessity, thus blurring the lines of traditional definitions of commercial sex.

### *5.2.2 Partner types by cohort*

Relationship style strategies differ for men and women. For women, the dominant cultural script of male sexual need and aggressiveness is met with a female script of guarded availability and inexperience.[55] A woman is expected to have sexual relations with her

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53. In Mozambique as elsewhere, sugar daddies are known as sponsors (*patrocinadores*) who help a young woman pay school fees or obtain a job.
54 FGD #706S / 21 years old / ♀ / 10th class / in school / sexually active
55 See Chapter 2.

boyfriend, but also seeks ways to secure the relationship with emotional ties – the 'have-hold' motif previously mentioned. While this fulfils an important function of mitigating the potential risks brought about by engaging in premarital sexual relations, it does not necessarily fulfil all of her expectations regarding relationships. Other relationship types may be sought out to satisfy these claims, such as those with economic benefit or a *pito* who offers companionship.

> If I'm married and I go have an outside [sexual] relation with a man ... that man is my lover. I'm going to have sex with him more than once. Now with a *pito* it's the same thing, I'm going to have more than one contact with him, yes.[56]
>
> Because I have two relationships at this moment doesn't change anything, not the way I am, I'm still devoted to my husband just like always ... it's just that sometimes, one or two times a month, I meet my friend. He's someone who helps me financially, we converse and exchange opinions. I don't consider him to be my *patrocinador*; he's there more for affection and to exchange ideas. ... My friend knows about my husband, but my husband doesn't know about him.[57]

For the younger women both in and out of school interviewed in the study, most have had more than one serious (principal) boyfriend since their first sexual encounter. Many also indicated that they maintain sexual relations with a secondary partner (*pito*) in addition to their namorado or instead of a serious relationship. Having a secondary partner is associated with an increasing ease with one's sexuality, greater experience, and more pleasure. Even with this sexual experimentation, few consider themselves to be at risk of HIV/AIDS or STIs. More women in school have chosen to delay their sexual initiation and consider themselves too young to have a boyfriend yet. They often refer to their close male friends as *pitos*, but without a sexual connotation. They may well have a principal boyfriend also and find themselves under considerable pressure to give in to his sexual advances. This theme will be returned to later in the chapter when discussing sexual initiation and coercion.

Contrary to the summary data where few casual partners were reported, in-depth interviews indicate that older women in school commonly maintained relationships with casual partners. Some women in this cohort depend on gifts and favours from sugar daddies in exchange for sex. *Pitos* were cited as a good friend or confidant with whom you can have a good time without the complications of a serious relationship. Another category of casual sex is the *saca cena* or one-night stand, to be taken up in Chapter 8.

Women out of school over 20 years old also indicated both stable partners (boyfriend or husband) as well as casual partners (friend or lover). In the summary interviews, nearly a third

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[56] FGD #707A / 18 years old / ♀ / 10th class / out of school / sexually active
[57] SSI #309A / 27 years old / ♀ / 8th class / out of school / sexually active

(28%) of this cohort reported being married or cohabiting with their principal partner. Frequently women in this cohort reported maintaining concurrent stable partners, but some distinction was made between a principal partner – one with whom they intended/hoped to marry, and the other who was there for companionship and sexual pleasure. Upon reflection over their sexual careers, many in this older group indicated positive changes in their sexual life had occurred and they take greater pleasure in their sexual relationships. With life experience has come an increase in the number of sexual practices, types of partners, sexual positions, and greater confidence to discuss issues of sex with their partners. However, some within this group felt constrained and inhibited in the practices they can suggest to their partners.

Male respondents reported various partners including main girlfriends [*namoradas*], occasional partners [*pitas*], and commercial sex workers [*vadias or putas*]. With time and experience, the older respondents both in and out of school indicated that they seek different sexual experience to break the monotony they often find in relationships with their main girlfriends. At the same time, with experience brings greater awareness of the risks of pregnancy and STI/AIDS.

The younger male cohorts still in school reported a wide range of sexual experiences. Some boast as many as nine partners in the past year, with four or more sexual relations per week. Others lack the opportunity and can go a year without having sex. Some report having sex in various positions, while others consider this to be disrespectful to the woman, stating "oral sex is sabotage … [it shows a] lack of consideration for your partner."[58] Different types of partners were noted, including girlfriends, *pitas*, and little friends [*amiguinhas*] with whom they practice oral sex. Most limited their sexual practice with their steady partner to vaginal sex. Secondary partners reported by men out of school over 20 years old included *pitas*, friends from their neighbourhood, survivors and *putas*.

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[58] FGD #804T / 21 years old / ♂ / 10th class / out of school / sexually active

A *puta* is sought after while out drinking at bars and informal kiosks. A *puta* is not necessarily considered a prostitute, rather she is defined as:

> A women that has sex with many [men] in exchange for nothing ... people call that a *puta*. You know there are women that well like sex by nature ... they like to have sex and they do it with many men, this is a *puta*. ... A *puta* is not a prostitute; she can't demand anything of me. I can go to her [for sex] ... you know that a friend of yours just had her, so you go there [and have sex] and after ... you call her a *puta*. This is bad manners [*ma educação*], after all who went there looking for sex? [but] she could have refused and saved her dignity. For example, in my neighbourhood there's a *pita* that will fuck [*foder*] any guy around, and ... we call her a *puta*. [59]

Younger men in school reported similar predatory behaviour. While they still maintained a main girlfriend and a secondary *pita*, this cohort reported up to 7 partners in the past year. However, a *pita* is usually someone known by the respondent for a considerable amount of time (over a year). According to this cohort, both *namoradas* and *pitas* are ideal types of partners. There are also *pitas* with whom penetrative sex is not yet practiced either because these women are considered companions or potential girlfriends.

> The difference between a boyfriend and a *pito* [is] I have a boyfriend and then I pick up a guy that has a girlfriend. [...] He's got his girlfriend ... [but she might] ... live far away or because you like it that way, simultaneous [relationships]. Anyway, I have my boyfriend and he [*pito*] has his girlfriend and because of this I could never invite him and my boyfriend. With a *pito* you can just have sex. The *pito* also has the same needs that my boyfriend has. He's a man and I'm a woman. They say that nowadays with a *pito* or a boyfriend anything can happen.[60]

Shifting categories and meanings

The terminology for different partner types constantly shifts across groups and ages. As indicated earlier, a *pito* can be an innocent friend with whom a girl might exchange kisses or hugs, but is not considered a sexual partner per se. For others, the *pito* is a sexual partner with little emotional attachment, but fulfils an important need for companionship. While overlap between the categories exists, the crucial difference between a *pito* and *saca cena* is level of commitment – a *saca cena* is someone who you never expect to meet again.

> A boyfriend could be a *pito* and a *pito* could be a boyfriend because they are similar. You could have sexual relations [with a *pito*] because they have the same needs as a boyfriend. You can have another partner [*saca cena*] in order to alleviate yourself sexually because you don't want to bother your boyfriend. A *pito* could be on Saturdays only to give tenderness and not be bored. [61]

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[59] FGD #804T / 21 years old / ♂ / 10th class / out of school / sexually active
[60] FGD #704T / 16.5 years old / ♀ / 9th class / out of school / sexually active
[61] FGD #704A / 16.5 years old / ♀ / 9th class / out of school / sexually active

This last passage indicates an important theme often returned to in the interviews. participants consistently justified their sexual actions based on biological imperatives.

> Let's imagine that I have a boyfriend and then I have another relationship with another person, I call this other person my *saca cena* [or] *vizinhança* [neighbour] ... [the latter] isn't boyfriend and girlfriend, but they are intimate.[62]

Often the definition of a secondary partner depends much on the context of the primary relationship. For instance, if the respondent is married, a casual encounter can be either a one-night stand or an affair. The following passage illustrates how this definition is driven by the principal relationship context.

> [MOD] *pito* and lover, what kind of relations are they, what happens?
>
> A *pito* is a lover, for example I'm married and I don't have my husband but I do have my outside lover. I can have sex with my lover more than once and have a boyfriend and *pito* also.
>
> [MOD] then a lover is a partner but without any responsibility?
>
> ... there's more responsibility because the woman is already married. ... a lover is a partner without responsibility in the strictest sense. the lover that I was talking about could be considered a *saca cena* ... well, in the sense that a lover is something more serious [weighty], but that's not of our level. ♀[63]
>
> The concept of lover depends on age; if they are still just boyfriend and girlfriend then he's a *pito*. When two people are officially married and there is another person, [that] is a lover. [64]

Partner types and condom: The negotiation of intimacy

Condom use is a marker of the level of intimacy and trust in the relationship (see Holland, Ramazanoglu, Scott et al. 1991; 1992). It can be used to define the relationship as well as the person. Categories of partner types change rapidly, since a partner can move categories from being a friend (with whom sex is practiced) to a principal boyfriend or husband. The abandonment of condoms is often a marker of an increase in intimacy and recognition of the new status for the couple.

> With the one I don't want, I always use a condom. I have more respect for [a girl] that insists on using a condom ... because I also want to use a condom ... I respect her more for using a condom because she plays it safe [*joga no seguro*] ... she doesn't want to ruin her career, if she gets pregnant she'd have to work to make money to sustain the kid, there are those that don't want this and ... [give up] trying to create a home ... it's better to let them continue [with school] until they get something better for the future and to have a family ... then it's ok to say, let's not use a condom so we can have a child ...

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[62] FGD #901T / 21 years old / ♀ /10th class / out of school / sexually active
[63] FGD #707A / 18 years old / ♀ / 10th class / out of school / sexually active
[64] FGD #704S 16.5 years old / ♀ / 9th class / out of school / sexually active

> When you have a girlfriend and she doesn't always insist on a condom, this on the one hand, could be due to over confidence on her part, or on the other hand, it might depend on you and if you don't trust yourself, you're going to use a condom, but if you trust yourself and her you might not use one. [65]

While power in relationships favours male dominance, women use the threat of commitment and social sanctions to manipulate a relationship. One strategy to secure a relation is pregnancy:

> [some girls] don't like to use a condom, they know that this guy is really great, they have him, so she gets pregnant, her father sends her to his [the boyfriend's] house . [66]

Sexual partners may adopt the use of condoms at the beginning of a relationship but later abandon condom use once trust has been established. Abandoning the use of condoms may well mark a transition to greater commitment, but as participants indicated in Maputo, the non-use of condoms outside the woman's fertile period can function as reward within a stable relationship.

> What she always insists upon is confidence in her ... because outside her fertile period, since I trust her, I'm not going to use a condom always ...[67]

Men represent the issue of trust and risk as temporal characteristics of a relationship:

> It [risk] depends ... I think ... we all have the same risk. I have my 'friend' [occasional partner] ... if it happens that she has a disease [STI] I'm going to have sex with her before the disease manifests itself ... then I'm going to have sex with my girlfriend and she's going to get it. I may have already accused her of [cheating], but it's the opposite, it was I that got the disease.[68]

Younger women also held a strongly idealised notion of what a relationship means. Even if not yet sexually active, most young women began to express their sexual feelings with boys in the context of a committed relationship which is seen as safe.

> [A boyfriend is] someone you pass the time with. I don't do everything with my boyfriend, only caresses, hugs and massages. With a boyfriend [you can] talk, kiss, exchange caresses. [69]
>
> Boyfriend is someone with whom you trade experiences, things that you can't speak about with your parents you can talk to your boyfriend about anything. there's an opening. [70]

Male informants reported the same strategy to assess and reduce risk within a permanent relationship.

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[65] FGD #803 / 19 years old / ♂ / 9th class / out of school / sexually active
[66] FGD #803 / 19 years old / ♂ / 9th class / out of school / sexually active
[67] FGD #803 / 19 years old / ♂ / 9th class / out of school / sexually active
[68] FGD #803 / 19 years old / ♂ / 9th class / out of school / sexually active
[69] FGD #702A / 16 years old / ♀ / 9th class / out of school / Not sexually active
[70] FGD #704T / 16.5 years old / ♀ / 9th class / out of school / sexually active

> in order to trust a person ... you need to converse with her, be together [with her and] love her ... [you] talk about lots of things, know what they like. it's like a friend, you see that this person is someone you can trust, what they're capable of.[71]

While this may be a mature approach to relationships, it is tempered with a cynical view toward fidelity.

> ... with a girlfriend there's a certain level of trust ... people think that they've arrived at a certain point where they've lived together for a long time .... then one of them betrays the other and the one that betrays could get sick and contaminate the other, someone that you thought could never one day betrays you.[72]

Younger women take a more cautious approach to the question of sex and partner type. The driving issue determining sexual practice within this group is fear of pregnancy. Safety comes in the form of the dominant cultural script of marriage and procreation where one can relax. For instance:

> [A] boyfriend/girlfriend is when two people aren't married. A husband and wife is when two people are married and live together. A *pito* is a kind of friend with whom you have *saca cenas*. The kind of relationship that you have with these partners isn't the same. With a husband, you are more willing to have sexual relations, it's more relaxed. With a boyfriend, you want to but you are scared about getting pregnant or getting a disease. With a *pito* you have the same fear as with your boyfriend, so you don't have sex always.[73]

In contrast, sexually active women less than 20 years old in school reported using condoms with all partners. In this case, the SSI indicate that a small group of younger women have taken on protective practices not as a means of distinguishing one partner from another, rather as an expression of self worth and as innovators. Risk, in this latter case, is not associated with partner type but with all partners. The question of innovators will be taken up in Chapter 8.

Condom use as a function of risk or risk as function of condom use

Nearly all sexually active respondents considered themselves to be at some degree of risk for unwanted pregnancy or contracting an STI or HIV/AIDS, usually due to an infidelity on the part of a partner. Those that do not consider themselves at risk justify this in a variety of ways: they take oral contraceptives, they have only one partner who is faithful, they have confidence in their partner, and or because they use condoms with an occasional partner. Few cases of consistent condom use with a principal boyfriend or girlfriend was noted. Mostly, condoms served to prevent pregnancy and were used during her fertile period or when there was some distrust the partner had an affair.

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[71] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active
[72] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active
[73] SSI #211A / 18 years old / ♀ / 9th class / out of school / sexually active

The driving force behind risk, however, is partner type. Few used condoms on a consistent basis and those who did used them to prevent pregnancy during the woman's fertile window. With a secondary partner, the use of a condom is associated with appearance, familiarity, or confidence one has in the partner. Condom use with a secondary partner is not solely a question of risk of HIV/AIDS or STIs, but tied to negotiation and power within a relationship (Díaz and Ayala 1999).

> There is a difference between those girlfriends that always insist on condoms and those that only insist on them to prevent pregnancy. .... the difference is this ... there are girlfriends that you're into but don't really like her, then there are those that you want to get pregnant on purpose so that you can stay with them ... [the other] knows that you don't like her that much and she'll do everything, like wearing mini-skirts ... that is, it all depends on you if you want to use a condom or not.[74]

Among older women in school, condoms are almost exclusively used with their secondary partners. However with sugar daddies, it is much more difficult to insist upon using a condom because of the stark power differential in the relationship.

> A HR does not want to hear that you have someone else and when he discovers [that you do] normally he leaves you. We usually lie. He doesn't want to use a condom, and he says that he can have another [partner], but if he finds out [that I do] he'll dump me.[75]

Participants in this FGD indicated there were two types of HRs. There is the single HR typified by the example above. This type is very flashy and likes to flaunt his wealth as well as sexual prowess. The second type of HR is the married type who is more responsible because he has a family to protect. As a result, the married HR will often suggest the use of condoms.

One 18 year old male student stated the only advice about sex that he got from his family was to be careful, to *prevenir* [prevent].

> In the first place, let me say that regarding sex, they [my family] always said the it's best to be careful, to see what type of person we have sex with ... they would always tell us [to be careful] ... but they never said that we could not practice sex ... they warned us that we should not have sex with just anybody, that we should study the person's character first ... how they are, where they come from ... you can't just go to bed with any girl you pick up.[76]

'*Ando prevenido*': Prevention as identity

Young people in Maputo take comfort in small acts of prevention, regardless of the preventive value, indicating that prevention is often more a self-concept than a practice. The

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[74] FGD #803 / 19 years old / ♂ / 9th class / out of school / sexually active
[75] FGD #707A / 18 years old / ♀ / 10th class / out of school / sexually active
[76] SSI #102T / 18 years old / ♂ / 10th class / in school / sexually active

common refrain voiced by many is "I am prepared" [*ando prevenido*], as if carrying a condom or possessing knowledge is sufficient to protect oneself. Assuming an identity of preparedness is potentially a positive step in the diffusion of condom use, however turning preparedness into action is not quite so simple. For instance, a common prevention strategy cited is the use of a condom exclusively during her fertile period and complemented by the practice of fidelity during the rest of the month. Here fidelity is relative. Fidelity by one does not guarantee fidelity of the other, a fact conveniently glossed over by most. Even though young people know this, the possibility of betrayal by their partner is too much to contemplate and thus 'being prepared' offers some succour. Similarly, temporary abstinence is used as a prevention method, even though abstaining from sex for a short period or from secondary partners offers little protection. The following exchange is a good example of this strategy:

> [MOD] you practice abstinence?
> There was a time when I tried that … it's relative
> [MOD] but, do you normally abstain from sex?
> Yes
> [MOD] for how long?
> I can't really say exactly
> [MOD] when do you abstain, then?
> When my schedule is really busy, and my girlfriend is studying, we don't have a lot of time together to talk. [77]

The following FGD participants alluded to the same relativism:

> There are many types of abstinence … if you don't have sex for some time; this is abstinence, even though it's temporary. For example, I've already practiced sex but now I don't want to, I can practice abstinence instead for a determinate period of time. During this abstinence, you can't have sex at all. [78]
>
> Abstinence is when a guy looks at a girl and says, 'I'm not going to have sex with you', but I could have sex with these other girls over there, that is abstinence. [79]

Despite knowing how to prevent STIs and HIV/AIDS, the study participants continue with behaviours that place them at risk. One potential motive for ignoring the risk of HIV/AIDS is that other, more pressing risks are ever present. Irrespective of age or education, the principal concern for young people is unwanted pregnancy. Because the condom serves more than one purpose, its use gives some informants additional comfort.

The forms of prevention presented by the informants included condom use, fidelity, and abstinence. Among women the meaning of fidelity and abstinence differed from the other

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[77] SSI #113T / 24 years old / ♂ / 10th class / out of school / sexually active
[78] FGD #801T / 21 years old / ♂ / 12th class / out of school / sexually active
[79] FGD #714T / 19 years old / ♂ ♀ / 10th class / out of school / sexually active

four cohorts. Those yet to start their sexual lives spoke first of abstinence as their principal risk reduction strategy and once they become sexually active most suggested that they would use condoms consistently as well as practice fidelity. Most of those already sexually active reported using condoms with their principal and secondary partners; however they diverged over consistency of use. Those under 20 years old and in school used condoms with both types of partners to prevent unwanted pregnancy as well as to prevent STIs and HIV/AIDS. Those over 20 years and in school used condoms with principal partners only during their fertile period to prevent pregnancy and always with secondary partners. Those under 20 years old and out of school used condoms in the same way with principal and secondary partners to prevent pregnancy. Other contraception methods are adopted by this group including oral hormonal contraceptives, the IUD, and injectables (Depo Provera). Older girls out of school rarely used condoms with their main boyfriends or husbands and opted for other contraceptive devices or practiced fidelity. With secondary partners condoms are seldom used reportedly due to a lack of ability to negotiate their use.

The power dynamics dictating responsibility for prevention sat predominantly with men, either as the agent of prevention or acceding to the wishes of his partner. Informants of both genders acknowledged the role and responsibility of the woman to introduce a condom to prevent unwanted pregnancy during her fertile period. However, outside this period the man controlled the use of condoms. To maximise the use of condoms, some women said they would lie about their fertile period and menstruation as a way of encouraging the use of condoms. Men accept the use of condoms with a principal partner during her fertile period. Sex during menstruation is widely considered to be polluting; thus sex during her menstrual period would require a condom.

Knowledge of condoms was nearly universal among those interviewed. In terms of utility, there are both advantages and disadvantages of using a condom. Advantages cited by informants include low cost, dual protection against disease and pregnancy, no mess, and to place distance between oneself and a partner. Disadvantages include a reduction in sexual pleasure, difficulties in manipulating the condom in the heat of the moment, discomfort for one or both partners, loss of erection, breakage/slippage, loss of intimacy, and stigmatisation of one or both partners as being unclean.

Most informants knew where to buy a condom if they needed them. However, most respondents have never purchased a condom even if they have used them. This is especially the case for women who see the responsibility of bringing a condom to a romantic encounter as the

job of the boyfriend as the man – "it's my partner who buys the condom" – which contrasts with the above observation that men require women to control their fertility.[80] However, with a *pito* …

> When I'm with my *pito*, or when I go meet him sometimes I buy them [condoms]. But most times it's he that buys them. Now when it's my *namorado*, we don't buy them because he gets them free from his club. [81]

Other women are not so trusting with their boyfriends …

> I buy the condoms because if I relied on my boyfriend he might say he forgets as a way of having sex without one. [82]

Teen pregnancy

A key theme identified in the interviews was the lack of preparation to practice safer sex at first intercourse. The general lack of knowledge as well as skills at delaying initiation, using condoms, and communicating with one's partner marked most cases studied. In the few cases where condoms were used at initiation, exceptional circumstances were noted such as the advanced age of one of the partners or exposure to information about condoms before the event. In the latter case, a combination of family members, peers, and external information sources from school informed the participant. For most, however, communication about sex and sexuality within the family results in the stigmatisation of the subject as taboo, while providing contradictory information at best and hypocrisy at worst.

> This depends on the level of intimacy with your parents. When we were young, they would say that you have to be careful playing, you can't do this or that, but they don't say what kind of games we could play. They only say that you can't play poorly, but we all understood more or less. Many times we asked [our parents] why and the mother turns silent and so does the father. So what do you do? You go looking for information elsewhere and we don't always get sufficient information. It leaves us confused [*desnorteado*]. We end up not knowing anything. We do have teachers that talk [about it]. At least we have the opportunity to ask them and they respond.
>
> There are parents that when you ask them, they respond badly and say, go ask your mother. There are parents that rarely talk with their children, they only want to know about your grades or if there was a meeting going on at school. … I talk about this type of thing with my mother more than my father. But there are things that even my mother can't know and only my father would know.

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[80] SSI #211A / 18 years old / ♀ / 9th class / out of school / sexually active
[81] SSI #212T / 19 years old / ♀ / 12th class / out of school / sexually active
[82] SSI #218A / 21 years old / ♀ / 6th class / out of school / sexually active

> There are things – situations – that are just difficult for us to understand. For example, in my case or with some of my friends, [a father] could be seeing [*namorar*] someone of our age and it's really irritating [*chateado*] to see that with a girl my age but he doesn't stop to think about it ... about what he is doing ... that he has a girlfriend the same age as his daughter. Then why doesn't he shut up [already] ... he should know that he can't have a girlfriend of that age.
>
> [Parents] say that only they know how to namorar, but they don't need to know how to namorar, it's us youth who need to know. The guys who namorar with you say that if you don't have sex with them they'll leave you.[83]

The lack of communication within the family is part of a larger trend observed by the participants, the inability of parents and their children to talk constructively about sexuality and HIV/AIDS. This generation gap between parents and their children seems to be an enormous chasm. Young people see their parents as anti-modern, traditionalists who cannot understand them nor feel open about talking about sexuality.

> For me, the problem is talking [about sex] with my mother ... that music was like a national anthem, she said [when they were young, they] would imitate that music in their own language and gain fame doing so. ... For them, that was something new; they didn't know what it was to party. For them, a party was going to ... a wedding. Every week we have concerts, the pool, discos ... they [parents] still think of another world ... they still have [not] even entered the Mozambique of today ... In their times, I don't know, they used gramophones, they don't know that life has changed ... today we have videos, the internet ...[84]
>
> In our parents time, for example, to talk about [sexual] positions I think for them this didn't happen, it was an insult ... but now if something that is already becoming the norm ... now on any given corner you can do it [sex] ... in school, in the stairwell [of buildings] it happens ...they did it too [parents] just they had more shame about it.[85]

The problem, however, is not simply the lack of communication between parents and their children per se. Instead of the parent-child relationship changing, rather the influence of macro trends of social, economic and demographic origin has altered the basic social organisation of the extended family in Maputo. Mechanisms that once dictated the proper behaviour of both parent and child required little negotiation over sensitive topics such as sexuality. Young people relied upon ritual initiation as well as the advice of aunts and uncles charged with transferring this information.

Study participants perceived pregnancy as a real threat to their ambitions as well as having significant social and economic ramifications. Young women often have to leave school, either at the request of her family or the school. While Ministry of Education policy does not require young women to leave school during pregnancy, young women often do as a

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[83] FGD #707 / 18 years old / ♀ / 10th class / in school / sexually active
[84] FGD #801 / 21 years old / ♂ / 12th class / out of school / sexually active
[85] FGD #803 / 19 years old / ♂ / 9th class / out of school / sexually active

result of peer pressure, prolonged absence during later stages of maternity and post-partum recovery, and subsequent child caring. The trend in school-leaving is consistent across urban and rural contexts where marriage of girls contributes to educational discontinuation (Meekers and Calvès 1997). If she is to return to school, she usually has lost so much time that she has to enrol in night school rather than rejoin her class during the day. See Calvès, Cornwell and Enyegue (1996) for a discussion of this trend across sub-Saharan Africa, particularly in urban areas, where pregnancy often forces female students to discontinue their studies. Abèga *et al.* (1995) found similar effects in rural Africa where early marriage of girls contributes to educational discontinuation.

One participant poignantly summed up the meaning of teen pregnancy based on her own experience. When asked about the most significant event in her young life, she responded:

> "... when I got pregnant ... I had to leave school and it was the saddest day of my life". [86]

For boys, considerable social pressure is placed upon them to recognise their paternity and thus social and economic responsibilities to sustain the child and mother. This also may result in the boy leaving school early to earn money and support the child and mother.

Some participants, principally among younger women, delay in initiation was reported as a protective strategy. However, more often young women learned about sexuality and contraception only after the fact. One interview illustrated the lack of knowledge about sexuality and reproductive health. This participant got pregnant at 15 years of age and she was sent away to the ancestral home in Manjacaze, Gaza Province (about 400 km north of Maputo). The child subsequently died at birth.

> [MOD] when you got pregnant, what did you think?
>
> "I regretted having known a man at this point, it only put me behind, in school, in my life, and it hasn't gone well. I don't have a good job, good jobs come when a person studies, without schooling there's no good job."
>
> [MOD] when did you discover that you were pregnant?
>
> "I only discovered at 8 months."
>
> [MOD] All this time, you didn't know? [surprised]
>
> "No, my belly didn't even grow ... when I ate sometimes I vomited, or I didn't get hungry, but I didn't know that I was pregnant." [87]

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[86] SSI #215 / 24 years old / ♀ / 6th class / out of school / sexually active
[87] SSI #218 / 21 years old / ♀ / 6th class / out of school / sexually active

As a social fact, this passage indicates how one woman came to justify her misfortune. Whether or not she knew she was pregnant is immaterial. Her denial indicates the stigma and shame associated with her predicament as well as the lack of resources to support her.

Sexual initiation

Sexual initiation is a vulnerable time for most women. They face situations and contexts with little preparation or social support. Few younger women were exposed to any kind of preparatory information at home. Even in those few cases, the kind of information is unlikely to expect the kind of sexual pressure most young women suffer. At the other extreme, a number of younger women interviewed expressed no particular interest in having sex in the near future. Their lack of interest is reinforced by the belief that they consider themselves still too young to have sex. Other stated reasons for delaying initiation include fear of HIV/AIDS, a general lack of preparedness, lack confidence in their partners, fear of becoming pregnant, and the concern that entering into a sexual relationship may ruin their plans to continue studying. For most young people sexual activity is opportunistic and depends greatly on access to privacy. Most often, this opportunity would afford itself at the house of the male partner or at a friend or neighbour's house. Isolated public spaces such as the beach or stairwells of buildings are also used.

Duress is the second key ingredient to sexual relations. In the vast majority of interviews, women came under tremendous emotional pressure to cede to their boyfriend's desire for sex. More often than not, the boyfriend has already initiated his sexual career. Women cite the emotional duress they suffer.

> It's blackmail! All the boys say, if you don't do it [sex] with me, as soon as you walk out that door I'll be with someone else. ... If we like him, in the end, we give in. [88]

Sexual initiation quite often follows a rigid set of events: an invitation to the house of her boyfriend or neighbour, isolation (in his bedroom or other room in the house, or on the stairways of the building), conversation, caresses, kisses, and vaginal sex. It often happens at the boyfriend's house when others are not present, such as after school. Rarely are condoms used, mostly do to a lack of preparedness. Respondents cited the heat of the moment, a lack of information about HIV/AIDS, and being outside her fertile period. In some cases, it was not a matter of choice.

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[88] FGD #706A/ 21 years old / ♀ / 10th class / out of school / sexually active

> When a girl refuses [and] delays giving in, she [is just] showing off ... women never show that they want to have sex, but they want to. They refuse at the beginning as a way of getting the man. But there are more women than men. You have to pressure them. ... Pressure is part of being a man. If you invite a girl to your house, you have to have her. She can't leave [the house] without having sex.[89]

Many women reported that losing their virginity was an unpleasant experience, but others were glad to get it over with. Younger women reported having sex for the first time out of curiosity, peer influence, pressure by their partner, and in order to secure a relationship. Regardless of the motivation, women cited their general lack of preparedness at the time of first intercourse. In retrospect many felt they acted too compulsively and regret having done so at such an early age. Women frequently regretted this first encounter, focussing on the risk of unwanted pregnancy, pain, and a feeling of loss or being used. In contrast, some cited a resulting closeness gained between partners as a positive outcome of a first sexual relation.

> I think that when guys ... pressure a woman, they come and talk to her. She gives in because on the one hand she may want to but on the other she's pressured to, and he has other motives that she has to accept.

For woman, there are strong social sanctions against ceding too quickly to the sexual advances of another or even demonstrating that she wants to have sex. From the point of view of the informants, to delay ceding is one of the strategies used by women to hold onto a man. For this reason, many times women will say no when they want to say yes, and it is seen as the responsibility of her partner to pressure her to know if no means yes or if no means no. Moreover, the context often determines how the situation will evolve. For example, if a woman is in the bedroom of the man it is implicit that she is not going to leave the room without having sex. The man justifies the coercion because if he does not pressure her into having sex, she will tell her friends that he did not pressure enough. His reputation will become stained and he will be perceived as being weak.

## 5.3 Conclusion

This chapter has presented a profile of the study participants both in terms of their socio-demographic background and sexual behaviour. In doing so, the participants were divided into eight cohorts as a means of critically comparing and contrasting differences in their sexual behaviour. The results indicate a number of trends previously undocumented in Mozambique due to a dearth of information on youth sexuality in the country. First, young people are highly aware of the risks they encounter in leading their sexual lives. Secondly,

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[89] FGD #801S / 21 years old / ♂ / 12th class / out of school / sexually active

despite the awareness of this risk, young people find themselves in precarious situations to which they have few resources to turn to. Finally, some within this group have assumed protective practices that insulate them from the context-driven rationalisations of risk.

This chapter highlighted the contexts which drive and give meaning to young people's sexuality, introducing the motivations for risk-taking and the social interactions which support them. The discussion included a review of sexual histories from first intercourse to most recent, as well as a reflection over patterns and trends that form youth sexual identity. Brief case studies were identified for many of the cohorts as a means of adding further context and texture to the interviews. One key finding was the stark lack of preparedness and isolation young people find themselves in initiating their sexual lives. It comes as no surprise, given the forces that push them toward sexual experimentation, the most pressing threat from the perspective of young people in Maputo is unwanted pregnancy. While the potential cost of an unwanted pregnancy may vary per cohort, it remains the central issue shaping youth sexual behaviour. The issue raises further questions about unseen costs of unwanted pregnancy including illegal abortions, and economic and social isolation on the part of the young mother and her child.

The adoption of an identity of prevention indirectly reflects the pressure placed on young people to act. To *anda prevenido* (to be prepared) may make an outward statement of one's worth, but fails to alter risk practices. Condom use as a protective practice is subjective, dependent upon more complex contexts of relationship types that dictate its use. Condom efficacy depends largely on temporal issues of when they are introduced, and how and why they are used in any given situation – as a contraceptive to prevent an unwanted pregnancy, for disease prevention with a commercial sex worker, or as a barrier to intimacy with a casual partner. Finally, the issue of sexual pressure and coercion were introduced as a cross-cutting theme to illustrate how gendered expectations and inequality of power in relationships places women at risk of unwanted pregnancy and STI/AIDS, irrespective of other factors.

The next chapter addresses the issue of behaviour change interventions and perceptions of risk in light of the trends described here. If such basic safe sex messages of abstinence, fidelity and condoms can be so easily twisted to suit individual risk coping needs, what hope do more complex communication campaigns have in altering basic behaviour? Using the example of a HIV/AIDS prevention activity, the behaviour change process will be examined both from the perspective of the change agent and through the expression of young people's own sexuality.

## 6 REPRESENTATIONS OF RISK: FROM INTERVENTIONS TO INDIVIDUAL

This chapter examines the question of message dissemination and perception by young people through an analysis of the *Jeito* Project's communications activities. Two behaviour change activities are considered: the *Só a Vida Oferece Flores* [Only Life Offers Flowers] radio campaign and the *fogo cruzado* peer education debate. The radio campaign will be referred to as the *Só a Vida* campaign throughout this chapter. Background to these activities is presented in Chapter 4 and elsewhere (Karlyn 1998a; Karlyn 2001). Both activities offer the opportunity to examine campaign messages within the context of an established behaviour change intervention. The radio campaign illustrates young people's sexual interactions, including the language, contexts, and gender ideologies perpetuating risk practice. Furthermore, young people are given the opportunity to express their own perception of risk, the situations which drive risk, and the resources they call upon to mitigate risk.

These two activities, the *Só a Vida* radio campaign and the *fogo cruzado* peer education debate, were chosen as examples of the application of behaviour change theory to AIDS prevention. The radio campaign began prior to the conduct of the fieldwork and continued throughout the fieldwork period. As such, it represented the overall AIDS prevention environment during which the field study was carried out. Importantly, the radio campaign was the only national AIDS prevention campaign conducted at the time of the fieldwork. This, combined with the fact that the author had access to programming documentation and evaluation data from the campaign, contributed greatly to the choice of the radio campaign as a case study. A text analysis of the campaign reveals embedded sexual scripts that reflect an institutional bias toward rigid risk contexts and gender roles. Similar contexts and gender roles are found in the *fogo cruzado* exercise. The *fogo cruzado* was used to explore locally defined risk constructs by allowing participants to express their own versions of partner interactions around safe sex conflicts. Again, access issues as well as compatibility with the script theory approach influenced the choice of the *fogo cruzado* as a topic of investigation. Furthermore, the *fogo cruzado*, as a narrative method, was easily incorporated into the structure and method of a FGD. See Chapter 4 for a detailed discussion of the methods used in addressing programme evaluation issues.

This chapter demonstrates how risk conflicts presented by the participants often failed to match those represented in the radio campaign and *fogo cruzado*. Study participants presented alternative risk contexts through reinterpretations of the *fogo cruzado* dramatisations,

as well as novel dramatisations which arose over the course of the activity. This exercise drew upon narrative research methods (see Chapter 4) to allow participants to present and interpret the conflicts they perceived in a given situation.

Four dramatisations are presented in the second half of this chapter. They present complex risk situations that young people must negotiate. The first dramatisation, 'Negotiation Style', illustrates how the one-dimensional, tidy responses offered by the radio plays and *fogo cruzado* lack the resilience to withstand the gender roles and power relationships that place women at a decided disadvantage in negotiating condom use. In 'Space as Determinant' we see how opportunity and location are important determinants in risk for young people. In 'Confrontation over an STI', we examine how risk and violence are intermingled as a wife confronts her husband after she is diagnosed with an STI. Lastly, 'Casual Sex Negotiation' captures the style of young people and demonstrates the variety of outcomes possible in a given interaction, which contrasts sharply with the linear conclusions presented in the *fogo cruzado*.

## 6.1 Implicit messages in mass media: The *Só a Vida* radio campaign

The *Jeito* radio campaign is based on key messages promoted through PSI communications strategy. The campaign uses characters and scenes from the play and centres each spot on a conflict situation with a modelled resolution.[90] Annex 11.10 presents the full text and characters of the So a vida play and radio spot campaigns. The campaign reinforces the key messages in the plays and makes them available to a much wider audience through the radio. The spots were designed to present the conflict situations in a simple, concise, real life context and give immediate advice in the form of key messages. This advice is meant to impart the knowledge and skills necessary to handle an otherwise tense and delicate situation.

The campaign consists of nine spots, all in Portuguese. The spots targeted both young people and adults by age and gender. Spots 1-3 targeted young men and women. Spots 4-6 targeted adult women in stable marital unions. Spots 7-9 focussed on adult men. Each spot was meant to represent real life situations focusing on HIV/AIDS and STIs (see Table 9).

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[90] The Project used four different plays including the flagship play, also called *Só a Vida Oferece Flores*, and three theatrical sketches, *Jeito com Jeito* [*Jeito* with style], *Essa Mania* [This Craze], and *Mulheres com Jeito* [Women with style].

***Table 9: Só a Vida radio campaign – Summary***

| Spot | Group | Personality | Key Words | Principal Message |
|---|---|---|---|---|
| 1 | Young Male | Rappers | Rap music. *Jeito* is not bad or prejudicial. | "Malta" (guys), let's be responsible, use a condom. |
| 2 | Young Male | Zé & friend | Zé, where did you go last night? It was a great scene. Carlitos is really bad with AIDS. | Condoms prevent STIs, AIDS and unwanted pregnancy. |
| 3 | Young Female | Guida & friend | Hi Guida, I'm a bit worried about Carla. | Practice safe sex or delay first sexual activity. |
| 4 | Adult Female | Marta & Auntie | Marta, it's been a long time since I've seen you. Why are you so sad? | Men, use a condom if you have an outside sexual relation, don't put your wife at risk. |
| 5 | Adult Female | Marta & Olga | Marta makes peanut curry for her husband. He's a lucky man. | Women should convince their partner to use a condom with outside partners. |
| 6 | Adult Female | Osvaldo & Marta | Osvaldo arrives home early. She is worried. | Negotiate condom use in a permanent relationship (between husband and wife) |
| 7 | Adult Male | Osvaldo & doctor | Osvaldo seeks doctor's advice. AIDS is for real. | Condoms protect if used correctly and consistently |
| 8 | Adult Male | Osvaldo & Francisco | Osvaldo is very angry. Women are crazy, they only want men who use condoms. | Use a condom to protect you and your partner. |
| 9 | Adult Male | Osvaldo & Alice | Osvaldo declares his love for Alice. | A person who appears healthy can be infected with HIV/AIDS. Condoms protect. |

Prior to their broadcasting, the spots were pre-tested and post-tested among the target audiences. Each was branded to promote *Jeito* condoms, and ended with a promotional jingle, key message tag line, price, and place available. The programmatic impact of PSI's radio campaign has been documented elsewhere using quantitative measures of behaviour change. The campaign contributed significantly to increased self-efficacy for those who heard the campaign compared to those who had not (Karlyn 2001). A regression analysis could not, however, determine which campaign element contributed to behaviour change, or which radio spot resulted in higher self-efficacy among the groups targeted. How well then did the radio campaign reflect the reality and needs of young people?[91]

[91] In examining the radio campaign, I make certain criticisms about its validity and effectiveness in representing the reality of risk from the viewpoint of young people in urban Mozambique. The analysis does not attempt to make evaluative statements about behaviour change outcomes due to the intervention.

Spot 5 illustrates how the campaign failed in terms of targeting. While the most popular spot across target groups, it was targeted toward adult women to promote inter-partner communication and negotiation of condom use within permanent (marital) relationships. Pre-testing of the spot was favourable. The spot suggests that a wife can broach the topic of condom use with her husband by preparing his favourite meal, which in turn would put him a good mood for such a serious conversation. Instead of appealing to the intended target group of adult women, the spot was much more popular with adult men. As a result, the campaign suffered from leakage across target groups, with some groups responding to spots not directed specifically at them (Karlyn 2001).

Spot 1 targeted young men using rap music to enhance the cool image of *Jeito*. Spot 2 also targeted young men and promoted the use of condoms to prevent AIDS, STIs and unwanted pregnancy. Spot 3 was directed at younger female listeners and emphasised the strategy of delaying first sexual activity. Spot 4 geared its message toward older women as a conduit to influence male sexual behaviour. Spot 5 targeted adult women and emphasised the negotiation strategies necessary to convince a husband to adopt condom use in sexual contacts outside marriage. Spot 6 promoted condom use for adult women, but focussed on the use of condoms within marriage. Spot 7 provided accurate technical information about HIV/AIDS and STIs for adult men. Spot 8 highlighted the difficulties for men in accepting the use of condoms in marital unions. Lastly, Spot 9 emphasised fidelity and the use of condoms as a sign of trust, seriousness, and commitment in relationships.

The campaign as a whole was meant to reflect the everyday life, focussing on conflict situations that young Mozambicans found themselves in. The subjects of the text were positioned as peers coming from the same social and economic milieu as the target audience. The texts portrayed a dramatic paradigm with a conversational or argumentative structure between two characters holding opposing or conflicting views. The two characters represented pairs either opposed, in the case of a woman trying to convince her partner to use a condom, or synchronic with the two characters supporting each other to convince a third party (her male partner) to use a condom (Spots 4 and 5). A similarly supportive pair was found among the two male characters in Spot 2, but opposition was established with one character as a condom user (and thus cool) and the other a non-user. Spots 4 and 7 contained characters imbued with symbolic capital. The Auntie in Spot 4 signified respectability and maturity, while the doctor in Spot 7 signified authority and technical knowledge. The former reinforced the intergenerational

support necessary to confront deeply rooted power dynamics in a relationship while the latter associates condoms with scientific validity and modernity.

The discourse represented by the text is predominantly masculine. Each spot presents a conflict situation such as a woman who suspects that her partner is cheating on her (Spot 4): she confronts her partner; he denies it; she employs indirect strategies to impose the use of condoms; he refuses but tentatively accepts; no definitive resolution is established. Other forms of exposition include a non-condom-user male who boasts to a condom-user male of his sexual prowess and non-use of condoms (Spot 8); the other user male promotes the virtues of condoms as cool, protective, necessary, and advises his friend to use condoms; the non-user rejects his friend's advice; the user reinforces risks of non-use and benefits (cool); and the non-user accepts his advice and promises to try. A similar exposition is found in Spot 3, but among two young women, with one a condom-user and the other an abstainer.

The binary oppositions evident from these discourses – female/male, faithful wife/cheating husband, condom-user/non-user, responsibility/pleasure – are significant paradigmatic elements of the text. If the female and male characters were switched, the text would take on a different meaning (see Table 10). By inverting the roles found in Spot 9, Alice is cheating on her husband rather than the other way around in the original text. She finds her husband's proposition to use a condom disagreeable. The discussion of disease brings about the contrast between trust in one's partner and the ability to judge the cleanliness of a partner by looks. Finally, Alice accedes to Osvaldo's wish to think about using a condom. In response, Osvaldo exercises his power in the relationship and imposes condom-use with the response that we will think with *Jeito*.

Upon initial analysis, the inversion of roles in this scene does not appear to radically change the meaning of the text. Since the relationship type is a secondary relationship, it is plausible that a woman could refuse condom-use with her outside partner with less concern for the threat of physical abuse or losing the relationship. Her attitude toward condoms is likewise plausible given the views of young people expressed in Section 5.2, she *andas prevenida*. In other ways, the inversion of the characters results in drastic meaning changes. The public exposition of a woman blatantly cheating on her husband would likely raise opposition by conservative elements of Mozambican society. It is expected that a man may cheat on his wife, but not so for women. Lastly, the denouement highlights the power advantage of the male character to impose condom use; however, in the original text the line 'think with *Jeito*' carries much less weight if spoken by Alice.

***Table 10: Spot 9 paradigmatically inverted***

| | |
|---|---|
| Alice | I love you Osvaldo. You are the only one |
| Osvaldo | You're such a liar, [what about] your husband? |
| Alice | Ah, that one. Imagine, he wants to try using a condom. |
| Osvaldo | He's right! |
| Alice | Not you too? Don't tell me you like to bathe with a raincoat on. |
| Osvaldo | There is a lot of disease around, and *Jeito* protects us. |
| Alice | But do I look sick to you? |
| Osvaldo | There are diseases that you can't see. Even a person that looks healthy could be infected. |
| Alice | OK Osvaldo. We will think about it. |
| Osvaldo | Yes my darling, but we will think with *Jeito*. |

Turning to other elements of discourse, contemporary music using rap as well as other music popular in Mozambique at the time of the campaign aligns the spots to current dance and music styles. These reality markers are meant to be obvious and anchor the texts as true to the experience of young people. However, the use of music as a marker can be tricky. Music comes in and out of style quickly, thus what was considered hot at the time of the conception of the campaign may be out of fashion once the campaign is aired. Furthermore, music styles are closely linked to identities. In Maputo, younger boys still in their adolescence tend to listen to rap music as a way of affirming their belongingness to the group or gang [*malta*]. Once these boys mature, they seek out other music, such as South African *Chicumbaze* and Cape Verdean *Passada*, which lets them express more individuality in their style, particularly as a way of distinguishing themselves from others in competition for the attention of girls.

The tacit acceptance of an external partner illustrates the gender bias instilled in the spots. In Spot 4, Marta suspects that her partner has another and confesses that she is powerless to do anything about it. Her Auntie advises her to try to convince him not to play around, and to insist on using a condom with him. In none of the spots did the female character have an extra-marital relationship. The threat of HIV/AIDS and STIs was mentioned in all of the spots; however the concern for unwanted pregnancy was limited to Spots 2 and 3, ostensibly directed at younger men and women. Spot 4 illustrates the intergenerational communication of sexual education, as a young woman spoke to her Auntie about problems with her boyfriend. Originally, the spot used the characters of mother and daughter, but pre-testing indicated that a mother who talked about condoms with her daughter would be considered inappropriate and immoral.

The reality represented by the spots obscures assumptions about the target group the spots were directed at. The male roles portrayed in the spots reinforce male domination in relationships. It is incumbent on the female partner to convince, trick, or cajole the male partner to use a condom – effectively she must restrain his sexual adventurism. When the Auntie responds to her niece's distress in Spot 4, she asks "what has he done this time?" a direct presumption of his culpability. Furthermore, the Auntie is less concerned about Osvaldo's philandering than whether or not he used a condom and weakly exhorts her niece to "try to convince him to be faithful."

Other reality markers used in the text include the often-repeated description of sex with a condom as taking a bath with a raincoat on (See Table 11). This metaphor is a strong rhetorical trope that is repeated in four of the nine spots. In Spot 8, the metaphor is cleverly countered with an equally powerful, although not commonly used, metaphor and subsequently inverted.

***Table 11: Reality markers in Spot 8***

| | |
|---|---|
| Osvaldo | But I don't like to take a bath with a raincoat on. |
| Francisco | Tell me, do you cross the road with your eyes closed? |
| Osvaldo | Obviously not. |
| Francisco | Osvaldo, open your eyes, AIDS exists and has no cure. |

While it is difficult to assess the power of the metaphor used, it is a well-established excuse for many men to avoid using condoms. A variation of the same metaphor also used is "you don't go into a pool and not get wet." However, the most commonly used metaphor to justify the non-use of condoms is "sex should be meat with meat (*carne com carne*)." More subtle metaphors are found in the text as well. The allusion to the disappearance of Ricardo in Spot 8 illustrates a common pattern of male economic out-migration to South Africa. Johannesburg is a metaphor for opportunity and risk; it is a place of no return. South Africa is a common destination for Mozambicans to seek work and many do not return. South Africa is also a place to obtain advanced medical care, and due to the gravity of the illnesses treated there, many do not return. A similar pattern of out-migration, from cities to the country-side, has been noted for PLWAs who return to their ancestral home for care and support prior to succumbing to AIDS.

Despite the potential risks associated with the double-meanings ascribed to *Jeito*, three of the radio spots use word-plays to emphasise the positive association of *Jeito* the condom and *Jeito* the lifestyle. In Spot 3, 'Y' declares that she and her partner "never do anything without

*Jeito* [style]." In Spot 6, Marta persuades Osvaldo by explaining that she wants to see his "style with *Jeito* [ability]." In Spot 9, Alice exhorts Osvaldo to be sensible and "think with *Jeito*."

The use of the term *Jeito* throughout the text is significant for several reasons. *Jeito* is a sign with multiple overlapping objects. *Jeito* may represent a condom as well as define a category of people or relationships. It is through the latter that *Jeito* exerts a primarily symbolic relationship between the sign and the signified concepts it represents. On a symbolic level, *Jeito* is rich in double meanings, signifying personal attributes such as knack, ability, sensibility, style, and flair. *Jeito* is used as a metonym whereby one signified form stands for another. *Jeito* the condom is positioned as a lifestyle concept, which symbolises safe sex, responsibility, and a positive future. Since *Jeito* was the first condom to be mass-marketed in Mozambique, it created and continues to dominate the national condom market. As with other classic products which create a market, *Jeito* has become the generic name for condoms in Mozambique.[92] On the positive side, brand association may result in near universal awareness of the product. In theory this should create a strong brand image insulated from potential negative associations. Nevertheless, negative publicity associated with a generic product, for instance if another brand of condoms or public sector condoms were found to be faulty, *Jeito*'s brand image would suffer as well. By establishing a positive discourse around condoms as a cool lifestyle brand, the *Jeito* campaign attempted to build brand equity to insulate the brand from negative shocks while carrying over positive attitudes toward the brand into their lifestyle and practices.

Inevitably, negative counter discourses arose in reaction to the *Jeito* campaign. Similar to that of other countries in the region, rumours abounded throughout Mozambique that condoms have tiny holes in them, the virus is embedded in the condom, AIDS was created to wipe out black Africa, and diminish the pleasure of sex (Schoepf 1995). More benignly, AIDS was infrequently mentioned by name in the press, rather the Portuguese term illness of the century [*doença do século*] was used, giving distance and stigma to the disease.

Regardless of the positioning attempted by the Project, *Jeito* inherits many of the negative connotations carried by condoms, including: promiscuity, mistrust, disease, emotional distance, lack of commitment, control, dispassion, and an interruption in spontaneity. The double-meaning of the term *Jeito* can also be a source of potential negative associations. The word is popular in Brazilian slang and diffused throughout Mozambique by Brazilian soap operas. *Jeito* and the diminutive *jeitinho* symbolise a loophole or means of getting around a

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[92] Durex condoms have attained this status in the UK.

problem, often through trickery or bribery. It can also indicate a bonanza because of luck or subterfuge. For instance, the expression hit the jackpot in English may be translated as waiting for my *jeitinho* to come in Brazilian Portuguese. This connotation of *jeitinho* place the locus of control away from the individual and onto a benevolent other; contrary to the sense of control in one's life the *Jeito* brand intends to instil.

Finally, each spot ends with a tagline – a memorable phrase used to close each message and reinforce the subject's memory of the spot and *Jeito* brand. The term *Jeito* is repeated in each spot more than 3 times. In addition, each of the three target groups receives a unique strapline, a secondary message directed specifically at the target group. The youth-oriented spots emphasise responsibility, "Let's be responsible, let's live with *Jeito*." The spots aimed at women reinforce her role to "convince our partners to use *Jeito*." For men, the announcer ends the spot with a plea to face reality, "Let's open our eyes, let's use *Jeito*." Consistent with the rest of the text, the straplines reinforce the same underlying themes that potentially undermine the validity of the campaign. The straplines include: "young people are irresponsible", "women bear the inequitable task of convincing their male partners to use condoms", and "men are in denial and must wake up to the need to use condoms."

The *Só a Vida* radio campaign highlights the limitations of rigidly targeted messages disseminated through the mass media. The difficulty in reducing complex sets of behaviours into radio spots that last under a minute may well contribute to these limitations. See Wellings and Macdowall (Wellings and Macdowall 2000) for a discussion on the use of mass media in health promotion. Moreover, the choice of reality markers and paradigmatic sequences reflect the perspective of the Project rather than the reality of the groups targeted. As we have seen, the radio text portrays formulaic scenarios that come to a quick denouement. The conflicts are primarily male initiated or male controlled. The resolutions are tentative and do not challenge the underlying power relations in the interaction. The campaign contributed to increased knowledge of HIV/AIDS, promoted a positive association of the brand with prevention practices, and influenced the intent of listeners to change their risk practices. At worst, the perpetuation of gender stereotypes and the missed reality markers identified in the text undermined safe sex messages by making them inconsistent with the lives of those targeted.

Next, I address this issue by allowing the young people who participated in the study to portray risk on their own terms through the narrative technique of dramatisation. First, I consider the implicit assumptions underlying another of the Project's communication activity, the *fogo cruzado* peer education debate. Then, I explore the improvisations young people

present as alternative constructs of risk. While the portrayal of risk by the Project is simplistic and one-dimensional, the corresponding response of participants was equally limited. What is important to consider is how risk is re-contextualised as social fact by participants.

## 6.2 In the cross-fire

Central to the Project's communications strategy is the *fogo cruzado*, described in detail in Chapter 4. Here, I illustrate the relevance of the Project to the research and to the views of youth targeted by the activity. Only Module 3 of the *fogo cruzado* is considered, which consists exclusively of dramatisations designed to evoke an emotive response by participants. The research introduced alternative scenes within the activity to explore the meaning of condoms in contexts outside of the construct presented by the *fogo cruzado* intervention. The interpretation of the alternative scenes were documented during several of the focus group discussions and presented below. The purpose of the narrative exercise was to stimulate the participants to assimilate the risk messages presented and to re-frame them into contexts that made sense to them. Accordingly, the narratives presented should be viewed as social facts and valid representations of young people's idealised reality.

A text analysis from the *fogo cruzado* demonstrates how the Project encourages participants to reflect on their risk of acquiring STIs and HIV/AIDS. Participants must assimilate protective sexual scripts and adapt them as appropriate to their circumstances. Dramatisations are used because they provoke an emotive response in participants. The symbolic elements of the dramatisation are particularly suited to discourse analysis.[93] These elements create a space for participants to manipulate signs – specifically the condom – across various contexts. In doing so, the sign becomes a symbol of the type of relationship in which it is used and in turn the identity the individual may assume.

The *fogo cruzado* presents a limited set of scenarios: a girlfriend and boyfriend negotiate condom use; a wife suspects her husband is unfaithful and suggests using a condom; a wife hears from work colleagues about condoms and suggests using them to her husband; and, a truck driver negotiates the use of a condom with a casual partner (see Table 12). Small but significant variations are injected to the scenarios. In some, participants are encouraged to mention STIs or HIV/AIDS in their interpretation of the dramatisations, and other times the participants are explicitly asked not to mention disease prevention. Each of these scenarios

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[93] Discourse refers to the ways in which people talk, think and conceptualise something. They contain a worldview, sets of assumptions and common understandings, and nonverbal cues to action (Pool 1997).

establishes a conflict that participants must resolve. Depending upon the skills of the moderator, the dramatisation can bring about tremendous variation in contexts and create powerful commentary on individual strategies for dealing with risk. However, cursory performance of the dramatisations stimulates only minimal involvement on the part of the participants. The participants tend to parrot back information from the previous two modules to the satisfaction of the moderator. While the moderator is provided with a list of questions appropriate to the scene used, the actual implementation of these probing questions depends greatly on the dynamism of the moderator, the degree of involvement of the participants, the quality of the dramatisation conducted, and the time allocated to the exercise. Under ideal conditions, the moderator will press the group for additional interpretations of the dramatisation and use them as a platform to explore the complexity and subtleties of the interaction.

***Table 12: Fogo cruzado dramatisations***

| **Dramatisation 1** | **Negotiation Style** |
|---|---|
| Target group | Youth |
| Characters | Girlfriend & Boyfriend |
| Objective | Negotiate safe sex with and without mentioning STIs and HIV/AIDS |
| Dramatisation | A couple (girl-friend and boy-friend) is discussing having sex, one proposes using a condom as a means of practicing safe sex. |
| **Dramatisation 2** | **Space as Determinant of Sexual Interaction** |
| Target group | Women |
| Characters | Wife & Husband |
| Objective | Negotiate safe sex with and without mentioning STIs and HIV/AIDS |
| Dramatisation | A wife, whose husband is a long-distance truck driver, suspects that her husband has extra-marital relations while away. |
| **Dramatisation 3** | **Confrontation over an STI** |
| Target group | Women |
| Characters | Wife & Husband |
| Objective | Negotiate safe sex with and without mentioning STIs and HIV/AIDS |
| Dramatisation | The wife heard from colleagues at work about the need to use condoms to protect against STIs and HIV/AIDS. Propose to your husband to experiment with a condom. |
| **Dramatisation 4** | **Casual Sex Negotiation** |
| Target group | Men |
| Characters | Truck driver & Casual Female Partner |
| Objective | Negotiate safe sex with and without mentioning STIs and HIV/AIDS |
| Dramatisation | A long distance trucker, during his trip, proposes using a condom with an occasional partner. |

Three configurations of partners exist: boyfriend/girlfriend; husband/wife; and, wealthy male/poor female. The first two couples are effectively the same, two partners in a stable, exclusive relationship. The boyfriend/girlfriend implies younger personalities; however the risk most pressing for this cohort, unwanted pregnancy, is not explicitly introduced. The participants are left to interpret whether the couple is negotiating sex for the first time, or if they are actually in a long-term exclusive relationship. These factors contribute to the authenticity of the situation and without these reality cues, the dramatisation may falter. A typical interpretation of the dramatisation would be as follows: she suggests using a condom, he refuses, she cites the risk of STIs and HIV/AIDS, he challenges her trust, she relents, and he reluctantly agrees to try using a condom conditionally.

For the two dramatisations targeted at married couples the interpretation differs little. The reality markers for both include the wife proposing condom use to her husband. The module produces the same basic sequential structure as the first couple. The discourse is limited to the wife in a deferential role to her husband. She must accommodate his extra-marital affairs and propose the use of a condom to protect her, which signifies his gendered role of protecting the family and the home. The other marital scenario projects a more progressive view of the wife as worker. Nevertheless, it is still she who must suggest using a condom. Her work may represent the intrusion of foreign ideas and the undo influence of her co-workers on the relationship. Wage earning on the part of the wife indicates a shift in the power dynamics of the relationship, which may be received with resistance. In this context, the condom may symbolise further emasculation and the triumph of external influences at the expense of the man. Shifting gender boundaries and roles is not new to Mozambique (Agadjanian 2002b) nor to southern Africa (Morrell 2000; 2001). Nevertheless, the negotiation of new roles within a relationship is bound to create conflict. Given the loaded scenario presented to the *fogo cruzado* participants, few of the dramatisations actually display such conflicts overtly.

The last dramatisation involves a truck driver who proposes using a condom during casual sex. It is understood from this interaction that he is a long-distance driver and away from home for extended periods. He may or may not have a family at home. The casual female partner may signify a younger woman who is a commercial sex worker or bar girl. Implicit in the scene is the economic basis of the sexual interaction as well as the gender power roles at play. The relationship is obviously economic because he is a truck driver, and presumably an older man with the responsibility of delivery of valuable cargo across large distances. Truck drivers in this context typically carry sufficient funds to reach their destination, and if they have

just unloaded their lorry, cash from the proceeds of the journey. The biological supremacy of the male libido is affirmed by the scene as it presents extramarital sexual relations during a long journey as a necessity. The appropriateness of his behaviour is not sanctioned, but the need to use condoms is. Would he refuse sex if she refused to use a condom? More realistically, could she refuse sex if he refused to use a condom? The latter presumes that she is in an economic position to do so. The suggested discussion appears to have no bearing on the scenario presented. The unequal power dynamics between the two partners would make the discussion of HIV/AIDS or STIs moot. If he wanted to use a condom they would, not the other way around. The moderator is meant to probe whether condom negotiation is inhibited by ability, vocabulary, dislike towards talking about sex, cultural issues (traditions, myths, and taboos), or lack of practice.

## 6.3 Local improvisation of intervention scripts

Four dramatisations were examined (see Table 12). The first, Negotiation Style, reflects an idealised negotiation of a girlfriend and boyfriend. She [the principal female protagonist] insists on using a condom as a means of protecting herself, but also to secure his commitment to the relationship. In this negotiation, she is willing to risk the end of the relationship over the use of condoms. The second dramatisation, Space as Determinant of Sexual Interaction, presents the neglected needs of younger adolescents who spend much of their time away from direct adult supervision. The dramatisations present the conflicts that arise when two students meet after school, ostensibly to study. The third dramatisation, Confrontation over an STI, shows a wife confronting her husband after she is diagnosed with an STI. Two scenes are presented, the first deemed unrealistic by participants and the second somewhat more reflective of how young people perceive such a confrontation. Lastly, Casual Sex Negotiation presents four different interpretations of a dramatisation. Each portrays the negotiation of casual sex in a bar, but with very different outcomes. Conflict arises based on participants' ideas about what is appropriate to do under the circumstances. The dramatisations are crafted to bring these divergent views together. Importantly, some of the dramatisations leave out the obvious reference to condoms and allow the dramatisation to unfold toward a number of possible conclusions. The dramatisations are not a completely neutral negotiation however, and as we will see from the focus group results presented below, resolution comes in a number of ways.

### *6.3.1 Negotiation Style*

Of particular interest in shaping prevention interventions is an understanding of the style of interaction young people engage in when negotiating condom use. To approximate such interactions, the narrative technique of role-playing was used during several focus group discussions.[94] The following interaction from FGD #714 illustrates a hypothetical situation: the female participant was asked by the moderator to attempt to prepare her boyfriend to use a condom the next time they have sex. The focus group consisted of 12 men and women with an average age of 19, out of school, a 10th class education and all sexually active. The two participants volunteered to undertake the improvisation and had not met prior to the focus group.

Summary:

| | |
|---|---|
| Target group | Youth |
| Characters | Girlfriend & Boyfriend |
| Objective | Negotiate safe sex with and without mentioning STIs and HIV/AIDS |
| Dramatisation | A couple (girlfriend and boyfriend) is discussing having sex, she proposes using a condom as a means of practicing safe sex. |

> [MOD] Now, you've already talked about this with your boyfriend, the last time you had sex he didn't want to use a condom and you ended up giving in ... now, how are you going to convince him to use a condom the next time?

The two participants discuss how they are going to portray the roles and after a few minutes they begin. The tone of the dialogue depicts a strong-willed woman who insists upon condom use with her boyfriend, even risking the end of the relationship.

> [♂] you know that I don't like using them
> [♀] yeah, but you have to use them
> [♂] I already said that I don't want to
> [♀] very well, then go find another [girlfriend]
> [♂] you're just going to leave me like that?
> [♀] well, I have this packet [of condoms]
> [♂] 'ehe', no, I don't want that [pointing to the packet of condoms]
> [♀] then fine, don't you remember that we spoke about this the last time? You insisted on not using one and I gave in.
> [♂] no, [I don't] remember that, now come on, get ready ...
> [♀] no, sorry, if you don't want to use a condom ...
> [♂] hold on ... hey, no ... you can't be like that
> [♀] if you don't like it, that's it

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[94] See the Chapter 3 for a detailed account of how narrative techniques were applied.

Once he fails to convince her otherwise, he accuses her of using the issue as a pretext to end the relationship. She must have another boyfriend whom she can control. Not only does this insinuate betrayal, but a transgression of gender roles that threatens male hegemony.

> [♂] now I understand, you have someone else, someone that does what you want
> [♀] I don't have anyone, except you. So, come on, let's do it...
> [♂] without a condom?
> [♀] with a condom, you heard me. [pause] Then, that's how it is.
> [♂] now, where are you going?
> [♀] I'm taking off
> [♂] hey, wait a minute
> [♀] I'm taking off, I'm finished with you, I don't want you anymore. I'm leaving, when you want to use a condom you know where to find me.

The improvisation starts again with the understanding that several days have passed. The boyfriend tries another strategy. He attempts to [re]establish the intimacy and seriousness of the relationship as a means of circumventing the need to use a condom. By affirming his intent to marry her, he acknowledges responsibility for any progeny and secondly establishes the exclusivity of the relationship. Once again the girlfriend refuses to submit, stating she wants to marry but not get pregnant. He reacts aggressively and accuses her of having a disease and of mistrusting him.

> [♂] Honey, you know that I can't stand this. Have you forgotten that we're going to marry? … but it can't be like this.
> [♀] Very well, but you also know that if you don't want to use a condom we're not going to marry.
> [♂] But how can we have children like that?
> [♀] But I'm not ready to have children
> [♂] Maybe I understand, I mean, you have some kind of disease.
> [♀] No, no I don't have any disease. I'm just scared of getting AIDS, it's not that I don't trust you but I don't know who you've been with.
> [♂] Now I see, you don't trust me, you're telling me that I have AIDS.

The negotiation ends with the girlfriend acknowledging his power – both social and biological. She concedes that men are free to have affairs and exert their needs. Upon ceding this authority to him, he accepts the provisional use of condoms as experimentation. Once he accepts the provisional use of a condom, he again asserts his dominance by insisting on having sex that day.

> [♀] No, you don't have AIDS, but I don't know who you've been with. Because men are more free, I know that you have your needs, one day I might not be with you and you might be with some 'little chick', you know how it is. … that's why I got them [condoms], to see if you would understand. You know that we only have 3 months to prepare for our wedding.

[♂] I know … but how are we going to have children if we use those things [condoms]?

[♀] Let's just try and experiment [with them] to see how we like them.

[♂] I don't want to … we've already been through this, there's no point going over [that] again.

[♀] It's that or nothing

[♂] So is that it? You're saying that [without a condom] you don't want to marry me anymore?

[♀] Well, if you don't want to [marry me], I'm not going to insist.

[♂] OK, alright … we can use a condom, but we're going to have sex today.

Upon concluding the improvisation, both participants returned to their seats and the conversation turned to interpreting what had just been presented. The group participants expressed their satisfaction with the scenario, although some doubted the woman's sincerity in leaving him. Others commented the negotiation could have concluded violently. From the girlfriend's perspective, the whole negotiation was about power. She only gave in when he reaffirmed his marital commitment to her.

[♀] For me it's quite simple, the non-use of condoms was postponed. He accepted sex with a condom [even though] he didn't even want to look at them. [but] he loves me and I could blackmail him that without a condom I would leave him.

[MOD] so the fact that he accepted to experiment with a condom is proof of love?

[♀] Yes, she [speaking of the character in the dramatisation] wasn't really certain that he loved her, but the problem is whether or not he'll use a condom after tomorrow.

The false assertion of female control over condom use typifies the negotiation style represented by young people in the context of the dramatisation. This is consistent in style with the way in which the *fogo cruzado* presents gender roles whereby participants find it reassuring, and perhaps even vindicating their own lack of self-efficacy, that gender roles can be challenged even if they don't believe such change actually happens. In this context, women are improvising through dramatic techniques how they may influence their partner's sexual practice by simulating the various scenarios in which condoms can be negotiated, anticipating likely outcomes and ways to counter them. In this next section, we see how context determines the options open to negotiate safer sex and consider circumstances in which individual agency has little to do with potential outcomes.

### *6.3.2 Opportunity and space as determinants of sexual interaction*

From the perspective of young men, the opportunity to have sexual relations should never be forsaken. However, a number of impediments present themselves in thwarting sexual opportunity. Firstly, there must be an available, although not necessarily willing, partner. Secondly, there must be a proper space in which the encounter can take place, one which

affords a minimum of privacy and discretion. When the opportunity for sex arises, it should be seized upon whether or not other less important precautions (i.e. condoms) may be available.

Opportunity figures prominently in the improvisations presented in this section and centres specifically around the control of space which determines sexual interaction. Young people often eschew condoms as a means of avoiding the risk of losing the opportunity to have sex. Moreover, condom use requires advanced planning and often such encounters are not foreseen or neither participant wants to undermine the spontaneity of the encounter. Producing a condom indicates the encounter was pre-planned and thus crosses a line in terms of the acceptability of coercion. The study participants tacitly accept sexual coercion as a biological imperative, but less so when it is wilfully manipulated. This theme will be taken up in the next chapter when we discuss the *saca cena* phenomenon and examine how public space becomes eroticised around sexual adventurism.

In the next improvisation which comes from FGD #807, space is used to create a normative pressure to force an unwilling or reluctant partner to cede to sexual demands. Space, in this case a young man's bedroom, is gendered. He exerts control over the sexual interaction by invoking his dominance of the bedroom as his domain. In his room he can close the door, take off his clothes, force her to sit on his bed, and ultimately force her to have sex.

Summary:

| | |
|---|---|
| Target group | Youth |
| Characters | Boyfriend & girlfriend |
| Objective | Negotiate abstinence or delay of sexual initiation |
| Dramatisation | A boy invites his girlfriend to his house to study. After arrival in his house, they go into his bedroom to listen to music, talk, and the door closes. They start to kiss, caress each other, etc. His intention is to have sex. She also wants to, but she doesn't know what to do because she is young and inexperienced. What does she do? |

[♂] Ah, let's study. There's this material that I don't understand, can you explain it to me? This expression … [he moves in close to her]

[♀] Alright, perhaps I can help you do it.

[♂] You know [stroking her arm], I've really missed you … [he feigns whispering in her ear] I'd really like to have sex with you, I don't know if you'd accept that or not?

[♀] No, well, no I don't accept it because I didn't come here to have sex. I came here to study. You were going to explain the things that I don't understand … sex has to wait for another day, another time. For now, let's just concentrate on our studies.

[♂] No, it [sex] has to be today

[♀] No, it can't be today.

[♂] If you really like me, you would do it.

[♀] No, I think liking and studying are different things. I like you but today it's not possible. I'm not ready for it, I'm not ready. Today I came with the mind to study.

[♂] It's not because today I want to, tomorrow I have to leave.

[♀]No, if you have to leave [tomorrow] you have to leave ... [when you return] you'll find me here.

[♂] It has to be today.

Up until this point, the tone of the interaction could be characterised as friendly with a style of jovial banter. We can infer from the modality of the conversation the two are a couple and probably have had sex before. Several symbolic resources are drawn upon by each in making their respective arguments. She invokes the original intention to study and subsequently calls upon other resources such as her psychological preparedness, which implies physical preparedness depending on whether she may be menstruating or in her fertile window. He highlights the temporal urgency by taking advantage of her presence in his room and stating that he must leave the next day.

The interaction then takes a more serious and aggressive tone, as it becomes apparent to each the other will not be easily swayed. For her, it becomes obvious the invitation to study was a mere pretext to have sex. For him, he realises that he can not get his way without coercion.

[♀] No, no way. I'm serious, today there is no way. I'm not ready psychologically.

[♂] I don't want to hear it [aggressively]... do you like me or not or do you have another boyfriend or something like that?

[♀] No, I don't have another boyfriend, but really, I am not ready to have sex!

[♂] Or maybe you've got something else [STI]?

[♀] No

[♂] Or arranged another boyfriend?

[♀] No, no, I don't have another boyfriend nor do I want another. It's because I'm not ready, I can't.

The suggestion that she has a boyfriend or an STI is used by the boyfriend to gain moral capital over her, especially given his weakened moral position of having lied and manipulated the situation in the first place. When this strategy fails, he uses more forceful language to gain her compliance by placing his emotional worth on the line. By imploring her in this way, he is creating a metaphor of compliance – rejection of his advances is tantamount to rejecting him and ending their relationship.

[♂] I'm asking you [imploring]

[♀] I know it's a request, even so I can't

[♂] Just one time?

[♀] No way, really, no way.

[♂] Do it for me

[♀] No, not even if you came to me crying, I not going to do it, absolutely not

[♂] No, this is not normal

[♀] Oh just be patient … it's a pain that will soon pass

[♂] It's a request [begging]

[♀] I know it is a request, but I can't

Exasperated, he breaks character and looks to the focus group participants for sympathy. It is obvious the modality of the dramatisation has its limitations and serves to constrain his behaviour. He plays to the audience by saying,

[♂] [TO GROUP] She is refusing, I'd take her and put her here [on the bed – indicating that he would force her to have sex]

The group participants laugh and indicate first their discomfort, but also recognise the reality of the situation. In real life, the encounter would probably already have resulted in violence or physical coercion. It was only the presence of the focus group which was constraining his behaviour to this point. The approval of the group, however, spurred him on as we will see next.

[♂] I'm begging you

[♀] No way, we're good friends, good *namorados*, but this … we can't do it like this, no.

[♂] I'm begging you

[♀] No way, insisting is not going to get you anywhere, no way.

[♂] Let's go. [grabbing her arm]

[♀] Don't force me, no way.

[♂] I can't even touch you?

[♀] You can touch me but you can't force me.

[♂] It's a request.

[♀] I know, you like me and I like you, but I can't … I already told you, it's not going anywhere because you're going to get all excited and from there you could attack me … let's just stop there.

[♂] Come on

[♀] No way, no way, I don't want to, I'm not ready for it.

[♂] Do it for me.

[♀] It's not going forward, I already told you, no way.

Again, he appeals to the group for approval to resort to violence. The interaction has descended to the point that neither can back down and save face.

[♂] [NB: to the group] I could just grab her violently. [all laugh]

[♀] I already said, no, no, no. [the repetition of no three times is understood by young people as definite] I'm not coming here to your house anymore because this isn't on.

[♂] Not that, no. You won't come [here] why?

[♀] No, I don't have another boyfriend and I don't like to come here to your house to study [if] you attack me.

[♂] I'm not attacking you.

[♀] You're being very aggressive, this just isn't on. No, I already said today no… another day yes, we'll plan it and have plenty of time and all, but today no. OK, I'm going. See you later.

[♂] Go! And don't come back.

[♀] No problem, see you. [all laugh]

[♂] Don't come around here anymore [he calls after her feebly as she departs].

Commenting on the dramatisation, a female focus group participant explained how an innocent invitation to study at a friend's house can be a dangerous proposition. Because they may be *namorados* or interested in one another does not diminish the disadvantaged position she may find herself in.

> [♀] … It's like this, you start classes for example and you see your colleagues and who you say that one yes, I like him, he'd make a good 'friend'. He could walk you home from school, have a snack, … [if] he comes to your desk, you feel really happy. So when he invites you to his house to study … dear he is not. But you don't know anything about this, he converses with you and everything and you like him, you might accept [having sex] …

From his perspective, the event offers an opportunity to have sexual relations. The lack of privacy, and thus opportunity, is a severe impediment for many young people in Maputo to have sex. When such an opportunity arises, it must be seized upon. The difficulty arises when such opportunities are unforeseen and precautions such as condoms are not available. The interaction assumes the dominant cultural script that men are always ready for sex, they should never refuse it, and sex should be unplanned and spontaneous.

> [♂] She might not have come there with that intention. One thing might not have anything to do with the other, but if she likes you … it's a question of opportunity. That's exactly it, opportunity. This is a real issue. Once the door of the room closes …. there's no problem … you can say that we're going to study. At that moment, you get close to her and start touching her and she likes being touched …

Given these observations by the participants, the moderator asks the same two individuals to reinterpret the scene. No introduction or direction is given, except for the following minimal setup by the moderator.

> [MOD] So you enter the room and close the door ….
>
> [♂] Here in my room I don't have a chair, I don't like to sit in a chair, you can sit on the bed …
>
> [♀] Thank you [hesitantly]
>
> [♂] So, can I take off my shirt. I'm in my room, as soon as I enter my room, I always do this [take off my shirt], I don't like to stay [in my room with my shirt on]
>
> [♀] No, you know that Nado, you can't take off your shirt in front of just any girl. At least in my presence, you can't do that, put your shirt on.
>
> [♂] No, you too can take off your blouse if you want to, if you're hot you can take it off.

[♀] No, I don't want to take it off. I only take it off in front of my boyfriend.

[♂] Don't worry, we're friends… then OK, we're here to study. [He moves closer to her and starts to touch her]

[♀] I don't want to Nado, I don't want to, don't do this Nado.

[♂] You know, there's something I want to tell you …

[♀] I don't want to, don't do this … I'm going to scream. I make so much noise you'll think I'm bad and you'll never want to see me at school.

[♂] You're going to make a lot of noise, but you know that we're alone here in the house.

[♀] Then let's just study, or open the door and I'll leave.

[♂] No, I think that … to tell you the truth …

[♀] I will do something that you won't like. Leave me alone if you don't want to see how bad I can be. Leave me alone because I don't want to … .

[♂] Yes, but you have really beautiful legs …

[♀] That's another issue thank you.

[♂] I like to watch you speak, this noise of yours, it's your reaction that attracts me.

[♀] Yes, I like you too, only the way you are I'm not interested … see what time it is? I have to do [*meter*] a lot of things that I really don't want to do.

[♂] I think that I should have had sex [*meter*] with you a long time ago, you know that I just didn't have the chance. [this is a play on the word *meter* – to put in or become involved with – which she used above.]

[♀] No, don't do that … you see this here now … Ah, let me leave, let me leave ….

Both scenes demonstrate an aggressive and pointed dialogue that takes place between the two over the course of the interaction. The paradigmatic cadence places him as the aggressor and she as the resistor. The flow of argument varies from the hard aggressiveness of his physical imposition on her to the soft begging for her compliance. The male character in the first scene invokes a normative pressure not to lose the opportunity for sex because he is going to leave tomorrow. She tests his long-term commitment by responding that he will find her there when he returns.

Opportunity also figures prominently in the second improvisation. He invokes normative pressure by exerting his control over the space, his room, as his domain. In his room he can close the door, take off his clothes, force her to sit on his bed (because he doesn't like to have a chair in his room), and ultimately (he hopes) force her to have sex. The scene ends with him proclaiming, "I think that I should have had sex with you a long time ago, you know that I just didn't have the chance."

In both dramatisations, when his advances are initially thwarted, he becomes aggressive and grabs her. This turns into accusation that she must have another boyfriend or a disease. Her refusal based on not being prepared is left vague. She offers to do it another day and plan it so

they have plenty of time. There are several possible hypotheses as to why she would take this position. It may be as straightforward as not being in the mood to have sex. The need to plan may also indicate that she can prepare to have birth control or condoms available. Another possibility would be that she is menstruating which would invoke a pollution taboo against having sex (Gengenbach 2002). While this belief remains strong among the young people interviewed in the study, many opted to have sex with a condom under such circumstances as a way of avoiding pollution. Likewise, if she rejected having sex because she was in her fertile period, condom use would also be the common course of action. Often, the informants indicated the acceptability to refuse to have sex under these circumstances, a position readily respected by their male counterparts.

At several points in the first scene, the male protagonist breaks character and speaks directly to the audience [the focus group members]. This happens at several key junctures where his tactics have been frustrated and he would otherwise resort to physical force. He declares "I'd take her and put here [on the bed]!" The group laughs partly out of discomfort but also in tacit recognition that he could do so if it were a real situation. At another juncture, he says that he would "just grab her violently" and gets more laughter in response. The participant appears to enjoy the power of the dramatic effect of talking directly to the audience, but it also indicates the normative constraints that he felt during the improvisation. Whether he would force himself on her is debatable, although realistic as the focus group participants indicated. Most forms of force are considered part of normal sexual behaviour to young people. The transgression of rape is very extreme and by default, any girl who willingly entered his bedroom would be seen as consenting. Nevertheless, the female characters in both improvisations use the recognition of his potential violence to control his behaviour. In the first improvisation, she gives him permission to touch her but not force her. He responds by softening his approach as a request (begging) rather than demand. She also softens her position by stating "I can't … it's not going anywhere because you're going to g*et al*l excited and from there you could attack me…". The other way to contain his aggression was to assert the norms of the relationship type. "We're good friends, good *namorados*, but this … we can't do it like this." Finally, both women threaten to leave to avoid further confrontation and possible physical and sexual violence. In the first improvisation, the female character declares that she will not come to his house anymore. Once rejected, he tells her not to come back. In the second improvisation, she threatens to scream and demands that he let her leave.

In the dramatisations we have examined how setting and context contribute to how young people express their sexuality. The settings identified in the *fogo cruzado* determined the terms of the subsequent interaction. The opportunity to have sex is very much constrained by physical (and emotional) space. A limited set of likely outcomes results as a consequence. One or both partners may be unprepared for sex and as a result condoms will not be used. Nor may sex be consensual, and physical and/or emotional coercion will be used. In the next dramatisation, we examine how disclosure of an STI is likely to provoke a similarly violent reaction. The dramatisation highlights the limitations of the use of social learning methods, such as the simulations used in the *fogo cruzado*, to increase self-efficacy around such disclosure.

### *6.3.3 Confrontation over an STI*

In this scenario, one frequently presented to couples throughout Mozambique, a woman discovers that her partner has given her an STI and must then confront him. The purpose of the dramatisation is to assist both women and men in confronting such situations through social learning methods – i.e. repeated exposure to simulated interactions with positive outcomes will contribute to better partner referral in STI cases. While the common modality of the situation may resonate strongly with participants, the outcome of such situations rarely ends without discord. The first scenario terminates with acquiescence on the part of the husband, which was met with dissatisfaction on the part of the participants. A second group of participants interpreted the scenario differently and illustrated the potential negative outcomes associated with such disclosure.

**Summary**

| | |
|---|---|
| Target group | Men & women |
| Characters | Husband and wife |
| Objective | Prevention and treatment of STIs |
| Dramatisation | A woman discovers that she got an STI from her partner. She hasn't had sex with anyone else. After she got treatment from the clinic, she returns home to confront her husband. |

[♀] I have this problem.
[♂] What problem, dear?
[♀] I [PAUSE] … I have an STI, but I don't know how I got it.[95]
[♂] Don't tell me that when I go off to work, you go out [of the house]?

---

[95] STI (DTS in Portuguese) is commonly referred to in urban Mozambique, such that it would not be considered strange for the wife in this dramatisation to use the term so directly.

[♀] No, I never had outside [sexual] relations. I'm amazed too because I only make love with you. It could only be you. You are the one who comes home from work at 10 o'clock or so.

[♀] But I have confidence in you. I married you because I loved you. You know that I'm old now, but I still function …

[♂] You don't think it's true, do you?

[♀] I've already been to the hospital.

[♂] OK, dear, tomorrow morning before work I'll go by the hospital first thing.

[♀] OK [all laugh, applause]

This dramatisation presents an emotionally charged scenario in a matter of fact manner. The husband takes the information that his wife has an STI with unrealistic equanimity. Then, he composes himself and reacts by accusing her of infidelity and neglect of her household duties while he is at work fulfilling his masculine role of the breadwinner. In turn, she blames him of infidelity because he often comes home late from work. His wife excuses his transgressions because she knows that she is now less desirable due to age. In the end he relents and tacitly admits culpability by promising to go to the hospital in the morning.

The perfunctory resolution of the scene belies the gravity of the conflict. The moderator asks the group to reinterpret the dramatisation with two other participants. Two new participants stand up in the middle of the group, after a brief consultation between them, they start.

[♀] [Talking to herself] He's going to hear it from me, dje!

[♂] Hi wife, how is it going? [entering the room]

[♀] No [angrily]

[♂] Huh, are you upset?

[♀] You know, *dje*! What did you do?

[♂] What I did was just get home from work. Maria, don't give me that face.

[♀] Father of *Antoninho* [she refers to her husband in the third person, as the father of their child]

[♂] Tell me now, it's my turn to be upset.

[♀] I'm sick.

[♂] Do you have malaria? Let's go to the hospital.

[♀] No, father of *Antoninho*, it's an STI

[♂] Oh shit [*porcaria* – literally pigpen, slang for something ruined or a disaster]

[♀] *Porcaria*, it's a bunch of pigs. [all laugh]

[♂] A STI?

[♀] Yes

[♂] But, damn, tell me this is a joke.

[♀] No, it's not a joke. I never made love to anyone else, you know that. You go around with your trash women and then come back here.

[♂] I'm faithful to you! Damn it!

[♀] You're lying.

[♂] [Turning on her] You can pack your bags now and go away. You got an STI and now you want to give it to me!

[♀] My father of Antoninho, you can't do that to me. You go wash that disease of yours. You went and had sex with someone.

[♂] Shit! [*porcaria*]

[♀] It could only be that other Maria from over there.

[♂] What a stupid woman! I can go away, no problem. Actually, I'm going now. Ciao.

[♀] Hey, hey. Aren't we going to talk?

[♂] Can't it wait for tomorrow?

[♀] Let's talk now. You go around with those trash women and then you come here and infect me?!

[♀] Then go to the hospital, go.

[♂] Let's go together.

[♂] You know it wasn't me.

[♀] Let's go.

[♂] Where to?

[♀] To the hospital.

[♂] But I don't have anything.

[♀] You don't?

[♂] If you talk about these things here, I'm going to hit you.

[♀] Heh, [just] try it.

[♂] What a stupid woman, you bring this illness into my house.

[♀] It's you that's sick. Come here, I want to see!

[♂] You want to see what? What do you want to see?

[♀] I want to see if you have an illness or not.

[♂] If you haven't picked up anything, I am going to kill you.

[♀] Kill me, let's go [to the hospital].

[♂] What is this? I never said that I was sick! [laugh, applause]

The second STI disclosure scene presents a much more aggressive and emotionally charged picture. The wife immediately confronts her husband and forces him to discover why she is so upset. She refers to him as the father of their son, which reinforces his position and responsibility vis-à-vis his familial responsibilities. Once he finds out the source of her consternation, his immediate reaction is one of shock and guilt. Then, in response to her accusations, he turns on her and tries to send her away. When she refuses, he threatens to abandon her. She exhorts him to go to the hospital with her for treatment. Again, he threatens her but this time with physical violence. The dramatisation ends without resolution, although it is understood that he will eventually relent and accompany her to the hospital.

The focus group participants indicated the dramatisation was too confrontational and would result in the wife suffering violence or abandonment. They suggested alternative strategies for her to pursue.

> Well, maybe she shouldn't be quite so open with her husband. She should not confess to having an STI but arrange another way to convince her husband to go to the hospital. There at the hospital the doctor with tell him that well the two of you have contracted an STI. Maybe the husband would face the truth that in fact it was he that brought the illness into the house. [96]

Others in the group reiterated this strategy, relying upon the authority of the hospital to obscure the nature of the illness or to force the husband to take responsibility for the illness. In so doing, the woman may avoid direct conflict with her husband.

> It's normal for a wife to tell her husband to go to hospital to do tests. Well, because today there are lots of things that it could be. She could say let's go to the hospital together to have tests done. They get there and do the tests and from there the woman might be able to avoid getting hit, separation, or fights.[97]

The *fogo cruzado* presented validates the secrecy and stigma associated with HIV/AIDS. In hiding the motive for visiting the hospital, the FGD participants mirror the stigma exhibited by health professionals in Mozambique and elsewhere. Instead of confronting the issue of STIs and HIV/AIDS, health workers often deny individual right to be informed of their medical status by making gendered judgements about what information an individual should have (Giffin and Lowndes 1999). For example, a woman giving birth in a Mozambican hospital who is found to be HIV positive may or may not be informed. The attitude of health professionals is one of condescension and pity. It's bad enough that she is going to die, why inform her (or her husband) and have her beaten and abandoned by her husband (Karlyn, da Silva and Duce 1994).

The *fogo cruzado* tacitly absolves men of responsibility. Men can continue with their high-risk practices and still attribute the appearance of an STI in the relationship to his wife. In part, this may be a reaction to the public humiliation that an STI would bring to the household. He may be able to treat his STI privately without anyone knowing, but if his wife becomes infected, it suddenly becomes the talk of the neighbourhood. This is an affront that he cannot abide and maintain face – "the secrets of my house and my wife are mine only .. and that's it."[98]

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[96] FGD#807 / 19 Yrs / ♂ / 8th Class / Out of school / Sexually Active
[97] FGD#807 / 19 Yrs / ♂ / 8th Class / Out of school / Sexually Active
[98] FGD#807 / 19 Yrs / ♂ / 8th Class / Out of school / Sexually Active

### *6.3.4 Casual sex negotiation*

Summary:

| | |
|---|---|
| Target group | Men and women engaged in casual sex |
| Characters | Man and woman in bar |
| Objective | Negotiate the use of a condom in casual sex |
| Dramatisation | The participant is in a bar and he meets a girl that he knows. He wants to have sex with her and she also appears interested, but he knows that he should use a condom. She's seated at a table at the other side of the bar. How will she react if he sends over a bottle of beer along with a packet of condoms, perhaps hidden in a folded piece of paper. The dramatisation begins as he approaches the table. Don't forget to include the issue of STIs in the conversation. |

In contrast to the dramatic paradigms presented in the radio spots or in the other *fogo cruzado* scenarios, this dramatisation directly reflects the reality of young people as presented in conversations with the research team. The young people interviewed described social life through the lens of *curtição*, which can be roughly translated as to have a good time, enjoy or delight oneself, or to hang out. A *curtidor* (playboy/playgirl) describes someone engaged in this life. The colloquial use of the word is of Brazilian origin and probably passed into Mozambican youth vernacular through the ever-present Brazilian soap operas that dominate local television.

As we will see from the dramatisations presented below, young people express their identity as *curtidores* in a variety of ways. Four scenes are presented. In each scene the male character is the aggressor and uses his charm as well as wealth to win over the girl. The flow and structure of the interaction can be characterised as humorous banter, with the man leading the conversation toward sex. The woman plays a traditional role of coyness and imposes barriers to thwart his advances as she assesses his suitability, invariably measured by his wealth. Each scene begins with a benign pickup line, closely followed with the male character offering to buy her a drink. She accepts the drink and the dialogue is directed by the man toward her availability. Where is her boyfriend? Does she come to the disco often?

He attempts to establish his credentials in terms of wealth, fame, or stature. She reciprocates and encourages him to continue, although she often places barriers to his advances as a test. At this point, the man directly or indirectly propositions her to have sex. This can take the form of a direct question or the implied commitment to accompany him outside or to another venue. By leaving together, an implicit contract has been struck and ultimately they will have sex. Condoms may or may not enter into the negotiation at this point. If not, it may be brought up at the time of the sexual act and thus not part of the dramatisation. The scenes end usually with her acquiescence.

In the first scene the girl puts up considerable resistance and maintains that she is faithful to her boyfriend. Eventually she relents not only to having sex, but to have sex with a condom. In the second scene the female character quickly agrees to have sex but refuses to use a condom. In the third scene, the woman refuses his advances and does not accompany the male character outside to have sex. In the fourth and final scene, the female character is swayed by the male character's wealth, as represented by his BMW car, and accepts to have sex with him. Condoms are not mentioned.

As noted in Chapter 4, a saturation method was used to drill down on topics as they arose, in order to ensure that the study captured the breadth of themes associated with the research topics while ensuring sufficient focus was applied to drill-down for an in-depth exploration of important themes. At the same time, delays in study implementation precluded the use of the *fogo cruzado* narrative technique until version 4 of the FGD discussion guide (see Table 5). As a result, the scenes presented in this chapter come from just one focus group (FGD #807) which consisted of men and women over 20 years of age who are sexually active. Like the other focus groups presented in this section, the group was structured specifically around narrative research techniques. The first dramatisation presents the scene as contemplated by the focus group moderator prior to the initiation of the activity. Variations of the dramatisation are then presented.

Scene 1: Successful pickup, rejects condom

[♂] Hi there girl, how's it going?
[♀] Good
[♂] Don't tell me that you're into this music?
[♀] I am a fan of [this] music
[♂] Me too!
[♂] Where do you live?
[♀] In the *Bairro 25 de Junho* [a peri-urban shantytown of Maputo]
[♂] 25 de Junho?
[♀] Yes
[♂] This is the first time at this disco for me, how is it?
[♀] It's a really good disco
[♂] Even though it's my first time here, I like it a lot [all laugh]
[♂] Let's go over to the bar
[♂] Would you like to have a beer?
[♂] Please, can I have two beers [to the bartender]
[♀] Thank you
[♂] This is the first time that people didn't recognise me
[♀] Oh yeah. You must have bad luck

[♂] Bad luck? Why? I never have bad luck

[♂] I'm very well known

[♀] You're well known?

[♂] Yes

[♀] What do you mean by that?

[♂] Well, I mean that it's not normal to know a girl who doesn't know my name, it's very popular

[♀] You are very popular?

[♂] Yes

[♀] Really, I'm very popular too! [all laugh]

[♂] Do you think it's right to mock me?

[♀] Mock you?

[♂] That's right

[♀] Ah, no … it's just a game. Let's just speak plainly.

[♂] That's alright by me. A game is a game.

[♀] It is a game, right?

[♂] Yes

[♂] I never gave you anything before in my life, take this.

[♀] What is this?

[♂] Unwrap it, you'll see.

[♀] Condoms?

[♂] Of course!

[♀] I don't use condoms.

[♂] But why not?

[♀] I have a boyfriend who is faithful.

[♂] Your boyfriend is faithful?

[♀] Yes.

[♂] Don't you see that I am faithful to you [too], [but] we have to use a condom.

[♀] And who is going to guarantee me that you're not a womaniser?

[♂] Womaniser, me?

[♀] Womanisers always carry condoms to take advantage of girls, do you think you're one of them?

[♂] No, it's normal. Sincerely, I like you.

[♀] You like me?

[♂] Yes …

[♀] Is that why you offered me condoms?

[♂] No, you know the first time we always have to use condoms.

[♀] Well … my boyfriend never told me to use condoms.

[♂] You're not with your boyfriend now, let's just leave your boyfriend out of this.

[♀] Now you're telling me to forget my boyfriend?

[♂] As much as you can forget, but right now you could forget your boyfriend.

[♀] Well, that is something I have to see, I don't know what to say.

[♂] The only solution is to go to bed with me.

[♀] I never used a condom in my life and you are now obliging me to use one.

[♂] [If] you've never used a condom in your life, there is always a first time.
[♀] You must think that I'm sick or something, I'm not sick.
[♂] Don't you trust me?
[♀] I don't know you, how am I going to trust you the first time?
[♂] Exactly, I don't know you either, that's why we use a condom.
[♀] Alright [relenting], then let's do it. [all laugh, applause]

In the opinion of the participants, the dramatisation presented an unrealistic view of the life of the *curtidor*. "The girl was very weak" according to one female focus group member. "How is it the guy demands to use a condom and she refuses and after he insists she accepts?" Another woman in the group concurred, "If I was the girl, I would have refused until he gave up."

Male participants in the group held a more pessimistic view of the female character in the scene. They distrusted her motives for not wanting to use a condom, suggesting that she was sick and since she would die of AIDS anyway, she initially refused to use a condom because she didn't want to die alone. Given the dissatisfaction with the dramatisation, the moderator requested two more participants to interpret the same scene. Here is their version of events.

<u>Scene 2: Unsuccessful pickup, rejects sex without condom</u>

[♂] How's it going?
[♀] Not bad
[♂] What's your name?
[♀] I'm *Mariazinha* [little Mary] [SOME laugh]
[♂] What a pretty name [he touches her backside]
[♀] Hey, don't touch me, be respectful!
[♂] I'm just getting some dust off your back [SOME laugh]
[♀] Oh … ok, thank you.
[♂] Would you like a soft drink?
[♀] A soft drink?
[♂] Or maybe a beer?
[♀] I would very much like a soft drink.
[♂] Let's go to the bar.
[♂] Hey [to bartender], 3 soft drinks for her [all laugh].
[♀] No, one is enough.
[♂] [to bartender] Give me one soft drink and one beer
[♂] [receives drinks] Thanks a lot
[♂] Eh! Do you have a boyfriend?
[♀] Of course, what do you think?
[♂] No, you know why I ask, don't you?
[♀] Why then?

[♂] I'm really into you, you know.

[♀] You're into me. But I'm not [into you].

[♂] I could do a lot for you in your life.

[♀] What do you do?

[♂] Me? I paid my bill and I paid for your drink.

[♀] That's it? It's only a soft drink!

[♂] I'll give you more later, if you know what I mean by later.

[♀] Ah! More later, more later is alright if you know what I mean [repeating him mockingly].

[♂] I bought this present yesterday for you, here take it [he hands her a packet of condoms].

[♀] Ah! What do you think? I don't take a bath with a raincoat on. Take it away! [she gives the condom back to him] I don't take a bath with a raincoat on.

[♂] This protects you.

[♀] Protection, what? Protection is for there [others], not for me here, understand? [Her emphasis is added by the use of Shangaan instead of Portuguese]

[♂] OK, if you don't want to, then we'll [just] leave it.

[♀] Listen, I don't want to use a condom, so if you want to then you better just go.

[♂] I'd rather not then. [all applause, laugh]

Upon witnessing this second interpretation of the dramatisation, the focus group participants clearly favoured the first scene. After watching the second scene, most of the women and many of the men in the group changed their minds about the first, and considered it to be more realistic. The group's initial reaction condemned the female character in the first scene as too weak, she did not adequately resist his advances. After further consideration and compared to the second scene, a female focus group participant commented that "the first scene is real because many girls in reality, after they are convinced, fall into line [and use a condom]".

In the first, the female character doesn't want to use a condom because of the significance of using one: that she is sick; or that she has been conquered by a womaniser. She accepts in the end, not because she realises "the importance of using a condom" as one male focus group member commented, but because he insists and she "falls into line". The second scene is remarkable for the lack of discussion about STIs or HIV/AIDS. To the participants, this rang less true because it indicated, according to a male focus group member, that "if the girl insists that much in having sex without a condom, logically I would think that she has something [STI]." The men in the group strongly agreed with the male character's decision to back out of the encounter. Both men and women in the group expressed distrust in the female character's motive for not using a condom – they give no pleasure and as she put it, "it's like taking a bath with a raincoat on."

Men in the group also suspected that she refused to use a condom because she was HIV positive. Both male and female focus group members backed up their argument with the following statements:

> "There are those that have the virus and their tendency is to transmit it to other because they don't want to die alone, and have to contaminate others."
>
> "[About] 85% of those that have it [HIV] want to spread the disease, they don't want to die alone, that's why it [the epidemic] is growing."
>
> "I heard from friends the majority say that if one day I get AIDS, I won't sit there with my arms crossed, I have to contaminate others."
>
> "A person doesn't want to die alone, he wants company. At the same time he dies another will take his place."

At this point in the discussion the participants were eager to develop new scenes with no encouragement from the moderator. Scene 3 presents an interaction that does not result in sexual intercourse; however the fourth scene does. Note that in these two scenes, the interaction focuses not on risk or condoms, but on the scripts men and women use to negotiate sex. This demonstrates the normality of engaging in casual sex as well as the powerful gender roles at play.

<u>Scene 3: Unsuccessful pickup, no condom suggested</u>

[♂] Uhuh! Please [to bartender], one soft drink. [To the girl] Do you want a soft drink or 2M [name of local beer]?

[♀] 2M no, I'd like a soft drink.

[♂] Do you have a '*dono*' by any chance? [*dono* means owner or master, and here refers to husband/boyfriend]

[♀] *Dono* I don't have, but boyfriend, yes I do have one.

[♂] You have a boyfriend?

[♀] Of course.

[♂] You know what I'm going to do? I'm going to put myself right under the nose of this boyfriend of yours. Where is he, I can't see him?

[♀] Sorry but I hate to say that won't be possible [indicates boyfriend is not present, but also that she is not available].

[♂] Why? Because you are faithful to your boyfriend?

[♀] Of course. It's not that I don't like you.

[♂] [Now quite full of himself] You know that I'm quite famous? You never heard of me, of David?

[♀] To be famous doesn't mean anything …

[♂] So you like me, huh? Then let's have a 'mini-date'.

[♀] A date? I didn't come here to this disco to pick up men, I came here to have a good time [*curtir*].

[♂] OK, but one day you're going to regret it.

[♀] No way! Regret … never brings anything better.

[♂♀] Ciao [simultaneously] [all applause]

Participants considered this third scene depicting a failed negotiation. A female participant thought the scene was realistic "because the girl was faithful and because the boy wanted to trick her [*driblar*]. The girl went to the disco not to *curtir* for men, but simply for fun. She didn't fall into his line even though he insisted." The female character's stated motive for going to the disco was to *curtir*, but not in the sense used in other dramatisations. The possibility of enjoying oneself and being part of the scene without having to engage in casual sex reflects the multiplicity of roles allowed for young women in Maputo. The security of a monogamous relationship functions as shelter for high risk behaviours in this context. "... had [she] not been faithful, she would have fallen into line. ... even if she didn't have a boyfriend, if she had fallen into line, it would have been with the object of dating the guy, not to have sex with him just to pass the time." The commentary did not condemn her for wanting to have sex. Female participants view her right and ability to engage in sexual activity as appropriate. The female character staked out her independence by insisting the she did not have a *dono* [owner]. Despite the absence of her boyfriend, she was spoken for. However, the proper way to negotiate such an interaction while maintaining respect would have precluded accepting sex "at that moment. She would have arranged another day to see him and have a conversation." If they had sex as a result of the second meeting, "it would be a secondary thing."

Male participants in the focus group were less generous in their assessment of both characters. The directness of the dialogue toward sex indicated that both characters were *curtidores*. "In less than 2 minutes from nothing to get to the point and from there have sex, the guy is a saboteur and the girl is also a player." The participant who played the male character noted the key point of the negotiation. Had she accepted to leave the disco with him, the outcome would have been sex. " ... when someone goes out of a disco [together] ... we talk and [I would] feel her up and she starts to feel ih ih! she, well, falls into line." This assessment indicates the potential for coercion, which was corroborated by a female participant in the group. "There are things the girls accept because they're afraid. ... [she] doesn't know what he's capable of. ... She might accept [to have sex] but there is no feeling [or] love." Coercion under these circumstances can be attributed to the space the interaction occupies, as we have seen in the previous chapter. The disco offers some safety but once outside, she has fewer resources to call upon and her ability to resist sex or define the terms of the sex diminishes. She is particularly vulnerable to rape.

Another important reality marker involved the purchase of a soft drink or beer by the man for the woman. In each scene, except for the first, the male character offers her a beer or a

soft drink. The significance of accepting a beer would have been remarkable; first because it means that she likes to party, and second because it opens the possibility of getting her drunk or at least free of inhibitions. All agreed that if she accepted any drink and consumed it, an exchange had taken place and she would be obliged to reciprocate with sex. Respondents concluded that her acceptance of the drink meant that she was in the game and only one result could come of that – eventually she would have to fall into line. His obligation would be to pay for all the costs of the evening and she in turn would reward him with sex. "I would consider that if she accepted to consume something [a drink] from an unknown [person] without anything else, it's because she definitely has another objective." The female character in Scene 3 did accept a drink but did not follow through with her obligations to have sex with him, thus undermining the validity of the scene in the eyes of the participants. Scene 4 portrays the logical conclusion of such a pickup predicated on this mutual exchange.

Scene 4: Successful pickup, no condom suggested

[♂] Hi there girl, how's it going?
[♀] Ah, good.
[♂] Well, can I have a little chat with you?
[♀] Let the music finish first.
[♂] OK, let's dance. Ih Ih! But before that, don't you want something to eat?
[♀] No, first a drink, I'm really thirsty [indicates that she is in the game].
[♂][to bartender] A soft drink please, and a pint of Laurentina [a local beer] for me!
[♂] Let me go lock the car … that's it over there, my BMW. Do you like it?
[♀] Yes. [nodding with approval]
[♂] OK, let's go to another disco.
[♀] Another disco? OK, let's go, no problem.
[♂] Uh [quietly] will you stay with me tonight?
[♀] Only that, let's go!
[♂] Uh huh! [all laugh, applause]

The reaction of the group to this last scene was polarised. Some considered her with moral outrage while others blamed both parties for behaving crudely. None explicitly blamed the man for taking advantage of her. The discussion came to indict all those engaged in the life of *curtição*. At first, the reaction to the dramatisation was incensed. A male focus group participant unequivocally condemned the woman. "This is prostitution! She fell into line after seeing his BMW. For as much as she may not have liked the guy, he's loaded … and drives around in a fancy car." Others cited this as an example of the game and both know the score. Despite that both are *curtidores*, the moral transgression of the interaction is squarely placed on

her. In her defence, the participants acknowledge that she is just following the logic of the situation. He has money and she does not. In the end, they both have a good time.

> This is reality. The disco is like this. He's a '*curtidor*' [playboy] and she is too. She says [to herself], 'I'm here to have a good time .... this guy is a *curtidor*, he's got money, I'm going to [*chular*] take advantage of him.' ... If she goes there and finds a guy that pays for her, that's all part of having a good time.
>
> She can go there without any money and say 'since I'm a girl I can make some cash with my body to *curtir*. He went to the disco with the objective of spending his money and to have sex. It's a night out, I think it's realistic.

Women engaged in this kind of sex for exchange in the discos distinguish themselves from commercial sex workers. While economically driven to engage in sex, their motive is not direct profit but to enjoy themselves, dress well, and have a good time. She has no money and her regular boyfriend has no money. As one male participant state, "instead she goes to a disco and meets men with a lot of money, [they] don't know what to do with it all. When a girl says pay for my drink, [you] pay ... [and] can't refuse. Only that when I pay for her drink, I'm already thinking about a lot of things in my head. She'll do anything ... whatever you ask she won't refuse. "

The issue of money is a sensitive issue. The receipt of gifts or unsolicited money distinguishes a commercial sex worker from a *curtidora*. Interestingly, these comments come from male participants in the focus group, although corroborated by women in the group. Men equally perceive the formal exchange of money as deleterious to her reputation and thus play along with the game of providing gifts and favours for her. Nevertheless, money does exchange hands.

> She [knows] he is loaded [*tacudo*] but she won't ask directly [for money]. She will try to show that her shoes are ruined. Since she is so pretty and elegant you feel ashamed to walk with her on the street with ruined shoes ... so you'll give her money to buy new shoes, new clothes, and then when you separate that's it, there's nothing more between you.

Men were quick to note that they were not always the aggressors. A woman may insist on paying for her own drink, which undermines the man's ability to demand sex. Women may also pursue men. In doing so she asserts herself as sexually independent. To a certain extent this is evidenced by the previous scene with the female character refusing to use a condom. Participants however saw this as rare and a deviation from her role as the pursued. It also serves to justify men's pursuit of women as being fair game. If women can do it so too can men.

> It's not only the men that chase the women, the women also are capable [of chasing men]. It's just that these cases are rare because there are few that are so daring. I think that this depends on the region, there are certain regions that stick to the law [rules]. After, they [girls] talk among themselves about how they had [*comer* – consumed] that one or the other.

One participant concluded the discussion by indicting both men and women. Particular approbation was given to women who no longer adhered to the rules of respectability. While rich men are guilty of taking advantage of their economic power, women flout the norms of responsible conduct. They ignore their parents, act independently, and chase after the first guy with money in his pocket.

> All of us here are guilty, the women too, because today is full of *curtição* [good times]. It's what is ruining people lately. The girls leave home without a cent on them and they go to the disco. The rich men are there to pay. At home the girls don't give any importance to their parents. *Eh pa*, they don't respect anyone at home. When you ask where are you going, she says 'I know how to take care of myself'. She's off to the discos. *Eh pa*, she looks at the guys there, then a guy pulls up in a car and [she says] ah! this one is for me. She stays by the door [of the disco] and then the guy arrives. He asks her to dance [inside] and she might say that she has no money. She won't say that she doesn't want to. [He pays] to enter the disco [with her] …

## 6.4 Conclusion

Behaviour change interventions work at the macro level to integrate the needs and requirements of their target groups, but ultimately methodological and structural barriers constrain the capacity of an intervention to respond to local contexts. In negotiating conflicts over risk and sexual expression, young people in Maputo constantly interpret the prevention messages directed toward them. How these messages are perceived and subsequently interpreted as safe sex scripts illustrates the process of message integration.

To demonstrate how behaviour change interventions reflect a socially constructed risk rather than an objective epidemiological risk, we examined the sexual scripts promoted by one behaviour change intervention. The text analysis of the *Só a Vida* radio campaign revealed embedded sexual scripts that reflect a bias toward linear outcomes and static risk contexts while underestimating the importance of gender ideology in shaping behaviour. The sexual scripts presented in this chapter illustrated how context and discourse shape youth sexual practice and risk behaviour. Awareness of the most common risk behaviours among young people does not translate into protective practices across contexts.

The analysis of the *Só a Vida* radio campaign highlighted the limitations of targeted messages disseminated through the mass media channel. The difficulty in reducing complex sets of behaviours into short radio spots was one important limitation unavoidable in a radio

campaign. Moreover, the choice of reality markers and paradigmatic sequence reflects the perspective of the Project rather than the groups targeted. The *Só a Vida* radio campaign portrays formulaic scenarios that arrive at simplistic conclusions which validate the gendered discourses driving risk practices among young people. The rote scenarios presented in the *fogo cruzado* failed to recognise the durability of gender ideology and structural factors in determining risk for young people in Maputo. In contrast, the narrative exercise stimulated the participants to reframe the risk messages presented in the *fogo cruzado* into language and contexts that make sense to them. Some of the improvisations offered novel ways for individuals to break out of the rigid sexual scripts reinforced by gender roles and larger cultural scripts. For example, in the dramatisation Negotiation Style we examined contexts in which men ceded power to women and in Casual Sex Negotiation women exploited gender norms to guide men toward more protective paths. Variation in gendered sexual behaviour offers space for innovation and change to reduce risk practices. The dramatisation Confrontation over an STI demonstrates how risk and violence are linked. The confrontation over male infidelity resulted in violence to uphold the male position of dominance. Finally, in Space as Determinant the important role of opportunity and location as determinants of sexual interactions among young people is highlighted.

Methodologically, the improvised dramatisations proved to be an effective tool to explore the meaning of condoms and allowed participants to reframe risk messages into paradigms meaningful to them. While the research activity never purported to evaluate the ability of the Project to achieve these goals, the analysis of the texts presented in this chapter illustrates how dramatisations work in the context of a behaviour change intervention. The dramatisations provided a behavioural script for participants to assimilate and adapt behaviour change messages as appropriate to their circumstances. The performative power of dramatisations was sufficiently captivating and stimulating for participants to explore sensitive topics such as sexual behaviour.

Next, in Chapter 7, I explore how gender roles provide limited variability and scope for men and woman to express their sexuality, desires, and concern for the risks they face. Social learning of gender roles reveals how young people come to acquire risky sexual practices. Through an analysis of the gender roles driving risk practice, I highlight how gender roles are regulated and maintained; lending insight into how such roles may be altered to diminish risk.

# 7 SEXUAL SCRIPTS AND THE REGULATION OF GENDER ROLES

In Chapter 5, I documented specific practices driving sexual risk-taking among young people and illustrated the heterogeneity of youth sexuality. The stark lack of preparedness and relative isolation young people experience begins at their first sexual encounter and continues throughout much of their sexual careers. The coercion and violence frequently suffered by women aggravate this isolation even more. Chapter 6 contextualised risk by contrasting the process of message dissemination with local perceptions of risk. I highlighted how risk is embedded in sexual scripts as well as the contexts driving such practice. Gender roles perpetuate such risk and serve to limit the ability of young people to explore protective practices.

This chapter examines sexual scripts by the risk perceptions they represent, the social learning that helps to internalise gender norms, the gender roles themselves, and lastly the safer sex discourses adopted by young people. Gender norms and the corresponding practices influenced by them are examined in terms of how they are formed and regulated. Specifically, I use the lens of transgression as an example of how gender norms are defined within the context of youth sexuality. Further, I examine how gender norms are regulated through violence and moral approbation, and resisted through counter-normative practices. The latter is supported by a case study of "the survivor". To explore these gender norms and corresponding roles, I discuss the process of social learning which teaches dominant scripts of masculinities and femininities. I then document how gender roles are elaborated and regulated, culminating with a discussion of the survivor as a form of social control and deviance found among young people.

## 7.1 Social learning: How young people learn about sex

Gender ideologies are internalised patterns of behaviour that reflect larger social and cultural norms guiding our daily interactions. These norms include the sexual attitudes and values which lead to everyday practice. Such ideologies are perpetuated through socially constructed roles defining how to act as a real man or proper woman. Gender roles are shaped and regulated by sanctions in the form of language and peer pressure through embedded meanings in language such as mass media, jokes, and stories. The internalisation of these cultural narratives is what gives gender roles such power, since few are aware of how they shape their individual behaviour.

The process of reflexivity of internalised behaviours is an important tool of self-discovery. The realisation there are alternative pathways to sexual expression other than the rigid roles young people see around them can be liberating. The biological imperative used by many to justify their actions, as we have seen in the Chapter 5, demonstrates just how rigid and at times oppressive gender roles can be. Through a reflection of the sexual scripts expressed in gender roles, young people themselves become aware of alternatives that pose fewer risks of unplanned pregnancy and exposure to STIs and HIV. The focus on gender ideologies and the social construction of risk is not intended to diminish the importance of structural determinants of HIV/AIDS transmission including poverty, economic dependence on one's partner or family, or legal regimes that limit individual agency. These factors all influence individual action. At the same time, the power of internalised modes of practice should not be underestimated. While individual actions may be driven by external forces, they are nonetheless personalised and have important meanings as a result (Foucault 1979; Jones and Porter 1994). Both internal and external forces combine to influence actions just as an individual may hold pluralistic and often conflictual conceptualisations of health, illness and the body (Braun and Kitzinger 2000). As a result, one's world view(s) directly shapes perceptions of risk and subsequent mitigating actions (Bastard and Cardia-Voneche 1997). Also see Laub (1999).

In the case of young people in Maputo, gender roles may be accentuated but are far from rigid. Underlying these claims is the commonly held stereotype that youth are sexually promiscuous, hedonistic, irresponsible, and short sighted (Aggleton and Warwick 1997; UNAIDS 1999b; Rivers and Aggleton 2001). Young people in Maputo exhibit a wide variation in sexual scripts, in part because of the varied contexts in which they express their sexuality. Individuals bring their own personal experience, past and present, real or imagined, to the sexual arena. The arena, or sexual scene, is further mediated by the context of a relationship and larger social norms driving behaviour.

Young people learn about sexual behaviour by direct observation or indirectly through a process of vicarious learning, symbolic interpretation, and self-regulation through trial and error (Bandura 1977b). Young people in Maputo learn about sex, sexuality, and the behavioural roles associated with each through several mechanisms identified in the study. Early learning comes from various forms of sex play while older children model their behaviour after their older siblings and parents. Communication skills are also learned and reinforced in the household. Those individuals who reported that they often spoke with their parents about

sex also reported more open communication with their sexual partners, greater assertiveness, and more protective sexual practices. The most common form of sex play reported is called mother-father [*mama-papa*], similar to playing 'house' in a Western context. The study participants defined *sexarche* (coital initiation) nearly exclusively as penetrative genital intercourse; however, many recognised that sexual activity begins before this. Respondents described their sexual experiences before sexarche as focussed on highly scripted sexual games.

> It was through games like '*papa-mama*' and things like that. [we would] play house ... one of the younger kids would be the child and the two older kids would be the father and mother.[99]

Historically, young people in southern Mozambique were encouraged to practice *gangisa* or intra-crural (thigh) intercourse as a means of satisfying one's sexual curiosity before marriage. The practice afforded young people the opportunity to learn sexual roles while avoiding unwanted pregnancy, especially when a pregnancy would have violated the rules of exogamy driving marital relations (Junod 1962 [1912]; Harries 1994). Harries (1994) speculates the practice of *gangisa* was also used to justify homosexual relations among male mineworkers living in same sex accommodation in South Africa.

Study participants were aware that they lacked information about sexuality and lamented that they could not speak with their parents about such topics. Instead, surrogates fulfilled the role of advisers on issues of morality, including sexuality. The radio spots presented in Chapter 6 give an example of how pre-testing of Spot 4 affirmed the taboo against speaking with a parent about sex; instead sexual advice can be given by an aunt. However, traditional roles of moral education do not necessarily coincide with modern, urban family forms where an aunt or uncle may not be present. The young people interviewed expressed their inability and frustration in communicating with parents about sex and sexuality.

> [Parents] say that only they know how to *namorar* [to date, make love], but they don't need to know how to *namorar*, it's us youth who need to know.[100]

Sex is infrequently spoken about in the house, and when it is discussed, the topic is considered taboo. Not surprisingly, young people learn that sex is secretive, off-limits, and bad to talk about or think about.

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[99] SSI #405T / 18 years old / ♂ / 7th class / in school / sexually active
[100] FGD #707T / 18 years old / ♀ / 10th class / out of school / sexually active

> My mother and father prohibited any talk about sex when I was a child. ... They said that we were children and that we shouldn't know about such things while we were still children. ... What was taught was that sex was prohibited, it was only for adults, and that it wasn't a game.[101]

Parents talk to their children about sex only reluctantly and in an indirect manner. The young people interviewed indicated that communication with their parents depends on the degree of intimacy with them. Most often, the advice given is evasive and forces young people to look to alternative sources of information. At times, adults treat young people as potential deviants. Few felt their parents accepted them as young adults, with sexual needs and desires. Young adults learn to suppress their sexuality and communication about sensitive issues in reaction to their parents' behaviour.

> There are parents that when you ask them, they respond badly and say, go ask your mother. There are parents that rarely talk with their children, they only want to know about your grades or if there was a meeting going on at school. ... I talk about this type of thing with my mother more than my father. But there are things that even my mother can't know and only my father would know. [102]

Like their children, parents are particularly concerned about unwanted pregnancy. One focus group participant illustrated the origin of her concern about unwanted pregnancy.

> My mother can be really annoying [*chata*] ... [she says] take care or you'll come to me pregnant and I don't want anymore babies. [103]

### *7.1.1 Masculinities*

Based on how gender roles and sexuality are learned, we now focus on how men and women apply these roles in their relationships. Social learning, as noted above, is a continuous learning process and functions both directly and indirectly. Direct social learning comes from overt instructions or physical experience. Indirect social learning comes from what is observed, heard, and inferred. Often what is not said may be a powerful tool in shaping gender roles. The ability to conceal, obscure or exclude is an important source of social and sexual power. This power takes on many forms – such as trust, desire, and pleasure – which play profound roles in the development of sexual identities for both men and women (Foucault 1981). Over the past two decades of research on sexuality and HIV/AIDS, there has been increasing attention paid to women's lack of power and gender inequality as a risk factor for acquiring HIV/AIDS (Farmer, Connors and Simmons 1996). While this line of research has been immensely important in highlighting the burden of HIV/AIDS for women, only recently has attention been drawn to the

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[101] SSI #107T / 20 years old / ♂ / 11th class / out of school / sexually active
[102] FGD #707T / 18 years old / ♀ / 10th class / out of school / sexually active
[103] FGD #705A / 21 years old / ♀ / 11th class / out of school / sexually active

role of boys and men (MacPhail 2003). How boys are socialised in relation to their sexuality illustrates the role men play in perpetuating risk practices (Connell 1994; Barker 2000).

Through direct and indirect learning, men discover the multiple masculinities that they will develop across their life course. Male gender roles categorise men as powerful and more important than women. Men express their power through risk-taking in various forms including fighting, sports, and violent behaviour with women. Men should be brave, adventurous, aggressive, strong, competent, logical, independent and always in control. In contrast, women are soft, gentle, talkative, caring, nurturing, affectionate, physically weak, emotional, expressive, and unassertive. Male identity discourages femininity as weak and powerless. Men view themselves as decisive while girls are perceived to be uncertain or acquiescent. Men assert their power as the head of household, through control over resources, and protectors of the family. He owns the land, the house, and the children. If he has paid a bride price, his wife is literally his property. He also has the power to either accumulate additional female objects (polygyny) or discard his wife and family instead of another.

Traditional male sexual scripts emphasise instrumentality and sexual prowess. This includes the denial of the expression of feelings or intimacy, and the focus on performance and being in charge. Boys learn that men should always want sex and that all physical contact leads to penetrative sexual intercourse and male ejaculation/orgasm. In Maputo, young men consistently expressed such rigid gender roles.

> Men always want to [have sex], from the 1st to the 30th [day of the month] they would have sex without a problem.[104]

A typical masculine sexual script requires the man to push for a certain outcome, he has a story in his head, the anticipation of which is arousing in itself, and it allows him to interpret what does happen in terms of what he hopes for. The goal-oriented nature of male sexuality justifies sexual pressure to achieve the desired end. After sex, men use conquest to affirm their status among their peers.

> [After sex] some guys will gossip about girls [to shame them]. ... A guy, after having sex, feels proud ... he walks around saying 'I had that girl.'[105]

Violence is seen as an acceptable and legitimate way for men to express their control as well as emotion. The often unwilling acquiescence of violence by many women perpetuates male power and control. Men justify their sexual predation based on the perceived biological

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[104] FGD #705A / 21 years old / ♀ / 11th class / out of school / sexually active
[105] FGD #714T / 19 years old / ♂ / 10th class / out of school / sexually active

need to have sex. Women are objects to be conquered and controlled in the pursuit of sexual satisfaction. Females resist but refusal to have sex is often discarded. Men interpret no as maybe and maybe as yes. At the other extreme, women should not have sexual desire or initiate sexual activity.[106]

> You have to pressure them. ... Pressure is part of being a man. If you invite a girl to your house, you have to have her. She can't leave [the house] without having sex.[107]

In much of sub-Saharan Africa, men control both the economic and social means of household production. In strongly patrilineal societies such as those found in southern Mozambique, a woman's virginity may be checked at marriage to ensure that she is unspoilt. While not a present-day practice, the ideology behind the practice does permeate attitudes toward gender roles among the young people interviewed (see Chapter 5). Men control female reproduction by deciding family size, birth timing, and contraceptive use. Women may subvert this control by using contraceptives without their partner's knowledge, which further undermines trust between the sexes. Men learn from their peers and male authority figures that women are not to be trusted. Contraception is seen as unnatural and potential dangerous to a woman's ability to conceive in the future, an important concern expressed by study participants as well as elsewhere in Mozambique (Gerrits 1997). The belief that women who use contraceptives might be unfaithful leads men to justify their control over contraceptive practice (Agadjanian 1995).

Condoms, in particular, undermine one of the primary objectives of male sexual practice – pleasure. Mass media objectifies women as vessels of beauty and sexual pleasure, exalting pleasure over responsibility or intimacy. Women are taught to place greater value on pleasing men sexually than on their own sexual pleasure. At the same time, women's economic well-being often depends on men in exchange for maintaining their sexual satisfaction.

### *7.1.2 Femininities*

Traditional female roles emphasise passivity, compliance, physical attractiveness, and being a wife and mother. Female sexual scripts label sex as either good (wanted) or bad (unwanted); masturbation is bad; sex is for men; men should know what women want; women should not talk about or want sex; and, women should not cede to having sex too soon in a relationship.

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[106] While not common to Mozambique, practices such as female genital cutting function to limit female sexual desire and pleasure.

[107] FGD #801S / 21 years old / ♂ / 12th class / out of school / sexually active

> Women ... should never have sex with a man until she knows him at least a month, otherwise the sex will be based on blackmail ... after that [the guy] would just leave you [if you did not have sex with him]. I think it would be good to wait up to 6 months or even 1 year [to initiate sex in a relationship].[108]

At the same time, some are cognisant of the norms that drive their behaviour and acutely aware of the inequality of power within relationships. Yet the woman interviewed feel unable to act upon this inequality. The possibility exists that perhaps men are not always ready to have sex or that women may enjoy having sex.

> The same way that he may not want to [have sex], she may not want to either. If there is respect, nothing happens. Women are not always disposed to have sex ... it depends on if she feels like it [laughter].[109]

Women place pressure on men to share power in a relationship, both in terms of sexual satisfaction as well as gender roles. Nevertheless, women tacitly accept men's biologically driven need to have more than one partner. The biological imperative of male sexual pleasure and satisfaction become paramount to a relationship. Men will risk everything including unwanted pregnancy, STIs, and HIV/AIDS to have sex without a condom.

> Men don't want to use condoms because they say they can't feel anything, no pleasure, it should be meat to meat [*carne a carne*]. It's difficult for his girlfriend if she wants to talk with him about [condoms]. She can't insist with all men, she'll give in and then accept [sex without a condom] in order to please him.[110]

Women are not supposed to express interest in or knowledge about sexuality or express their sexual desire in any way. Outwardly, women are taught to be reserved and subservient to men.

> Our mothers teach us that we have to be reserved [and control our] desire. ... However, even though girls are more reserved outside the house, within the four walls it's something else, she can be hard and she does everything [but] she fears being called names like a slut [*vadia*] or prostitute [*puta*].[111]

## 7.2 The regulation of gender roles

To examine how gender norms become manifest, I first describe some of the consequences of deviation from proscribed sexual roles and then trace how transgression actually fulfils an important mediating role in introducing change in gender relations among young people. While violence effectively controls female sexuality in many contexts, several of which will be explored below, significant confrontation over the boundaries that control

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[108] FGD #707T/ 18 years old / ♀ / 10th class / out of school / sexually active
[109] FGD #714T / 19 years old / ♂ / 10th class / out of school / sexually active
[110] FGD #714T / 19 years old / ♂ / 10th class / out of school / sexually active
[111] FGD #705A / 21 years old / ♀ / 11th class / out of school / sexually active

sexuality was found. Transgression thus plays an important role in defining boundaries of appropriate and inappropriate behaviour. Importantly, the multiple meanings transgression imparts on a particular sexual act contribute greatly to sexual identity among Maputo youth. By defining and ultimately negotiating boundaries of sexual practice permitted in various types of relationships, transgression defines youth erotic scripts. The survivor lifestyle is presented as an example of how violence and transgression combine to form a unique social identity with concomitant practices that place young people at disproportionate risk for HIV/AIDS and STIs.

### *7.2.1 Sexual violence*

Violence plays an important part of everyday life among young people in Maputo and sexual violence is a constant threat and source of oppression (Dgedge, Novoa, Macassa et al. 2001; Pacca and A Mohamed 2002). The issue should be paramount for policy-makers because of the heightened risk of HIV transmission under coercive circumstances as well as the failure of HIV/AIDS interventions to adequately address the issue programmatically. Interventions promoting women to challenge power inequities may actually exacerbate tension within relationships and lead to negative consequences for the woman, including violence (Maman, Campbell, Sweat et al. 2000). In the same way, sexual scripts are so ingrained in everyday practice that deviation from those scripts, however harmful they may be, can seem more dangerous or threatening than the actual innovation.

> There are aggressive men, you see that a person might not want to [have sex] but if he insists ... he could beat you or tell you to leave ... if you have kids, it's better just to stay at home because you do not have anywhere else to go ... one of my children is still breast feeding, and if he insists, I can't go anywhere because where am I going to leave my children? This is why I have to stay.[112]

Violence and economic dependence often go hand in hand. The lack of alternatives in terms of source of income, housing, and a paternalistic culture which favours male ownership of both wife and children make the prospect of separation a less palatable option for many women.

> Let's say that I have 10 kids at home, not even my mother would let me return to her house ... there is no space for me and my children. What can I do, only put up with him, he's the father of my children. Also, to have children without a father just because of this, that's not normal. It's a disgrace, but I do not have any other option, I have to do what he wants ... I could take the children to my mother's house and find another husband [but that] would only make the situation 1000 times worse. It is for this reason that we put up with them our husbands, parents or boyfriends.[113]

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[112] FGD#708T / 18 years old / ♀ / 7th class / out of school / sexually active
[113] FGD #708T / 18 years old / ♀ / 7th class / out of school / sexually active

Violence was equally accepted within the context of a cohabiting relationship as within a formal marriage setting. One woman of 21 years reported that she had "never suffered from abuse or forced to have unwanted sex."[114] Later in the interview, however, she indicated that in fact her ex-boyfriend would force her to have sexual relations with him. Since they were living together at the time, she did not consider this to be sexual violence.

> At least from my point of view it wasn't violence, but I guess it could be considered an act of violence. We would fight a lot, it was as if we were two men in a boxing ring. When he wanted sex and I refused, he would say "and what are you going to do?" He would force me and put himself on top of me.[115]

Sexual pressure and coercion were commonly cited as a source of concern for female participants in the study, permeating most discussions of past and current sexual relationships. Most striking is the acceptance of violence as normal. Most of what is characterised as sexual pressure in Maputo would be defined as rape in any other context (Heise 1993; Heise, Moore and Toubia 1995; Garcia-Moreno and Watts 2000; Maman, Campbell, Sweat et al. 2000; UNFPA 2000). For both young men and woman in Maputo, rape consists principally of the use of physical force, particularly by a stranger or by someone significantly older than the victim. Sexual pressure is everything up to the point of using physical force – coercion, physical threat, peer pressure, and emotional blackmail. Gang rape [*geral*] was mentioned repeatedly by both men and women during the individual and group interviews. Although the practice had become less common at the time of the survey, respondents indicated the practice had reached epidemic proportions in the *bairros* just after the Rome Peace Accords of 1992.[116]

> *Geral* is when several men rape a women ... a group of them will get a girl drunk at a party ... once she's inebriated it can be considered rape. But if she wants to then it isn't rape. Rape is when there is no corresponding will on her part.[117]

Even under these most extreme circumstances, the notion of consent either explicit or tacit, changes the meaning of the practice from the perspective of male hegemony.

> *Geral* is something that's been planned. For example, a group of friends plan to rape a girl and they all go. The girl may have agreed to have sex with only one guy, but he invited his friends to join him ... But it's not rape if she agreed to [have sex in the first place].[118]

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[114] SSI # 312 / 21 years old / ♀ / 11th class / Out School / sexually active
[115] SSI # 312 / 21 years old / ♀ / 11th class / Out School / sexually active
[116] Participants speculated that gang rape was particularly common at that time because of the overall lawlessness that had overwhelmed the peri-urban bairros of Maputo during the end of the civil war and run up to elections in 1994.
[117] FGD #706A / 21 years old / ♀ / 10th class / out of school / sexually active
[118] FGD #707A / 18 years old / ♀ / 10th class / out of school / sexually active

The difference between sexual pressure and rape, in the view of the respondents, is the use of physical force. Given the highly restricted definition of rape used by the informants, few women in the study reported to have been raped. However, nearly all participants in the study reported coercion or sexual violence in the past, either as perpetrators or victims. Sexual pressure includes any strong insistence, threat, blackmail, or forceful conversation used to convince a woman to cede to the sexual advances of another. Accounts of this practice occurred within the context of stable relationships as well as casual encounters. Even in some cases, the use of force is not considered a rape, as is the case of rape within marriage.[119] While Mozambican society does not explicitly condone the use of force in the context of marriage, consent is nevertheless implicit in the institution of marriage. Outside of marriage, pressure that results in consent (implicit or explicit) is not considered rape.

The use of violence to maintain the social order of sexual dominance by men over women is an important element of the sexual scripts young people witness and emulate. In stable unions, women accept male dominance regardless of whether or not they are aware of their oppression. The social norms regulating men's view of sexual dominance are correspondingly vague when it comes to violence. A great degree of latitude is given to men and they are only censured if a greater public transgression is committed, such as the case of violent sexual assault by an older man or stranger against a young innocent woman. Incest, for instance, is strongly condemned by Mozambican society. It is the public nature and corresponding shame of rape (as defined locally) that distinguishes it from private acts of sexual violence. As long as sexual violence is hidden behind the veil of normality, it will be accepted as a prerogative of male superiority.

### *7.2.2 Boundary setting through transgression*

At the other extreme of transgression, challenges to sexual norms may result in titillation and sexual excitement. Risk may function as an objective itself. A common form of deviance noted by young people in Maputo was to engage in sexual acts in public spaces such as the beach or stairwells. The use of public spaces for sex is partly due to a lack of opportunity for privacy, a problem common to young people and other marginalised groups elsewhere. Public sex venues represent a lack of opportunity as well as titillation (Dowsett 1996; Jackson 1997; Keogh, Beardswell and Research 1997; Flowers, Marriott and Hart 2000; McCamish, Storer and Carl 2000; Asthana and Oostvogels 2001). But some indicated other motives. Having sex

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[119] Mozambican law is ambiguous on this issue.

in public places adds the element of risk to the act, the risk of being found out. One respondent explained why he prefers sex on the stairwell:

> For me, the best place [to have sex] is the stairwell, because when you talk about the stairwell you're talking about risking it, and for me there's more pleasure in it.[120]

Anal sex is another form of transgression that brings either approbation or titillation. According to some respondents, the reason for not practicing anal sex is hygienic. What drives such behaviour, however, could be characterised more by power and pleasure seeking. With a principal girlfriend, men cannot impose unconventional sexual practices because they would be considered disrespectful; it violates those boundaries of acceptable sexual behaviour within a primarily procreative relationship. The same logic could be applied to the use of condoms. Condoms limit the potential for fertilisation and thus undermine male authority in the relationship. The unnaturalness of condoms contradicts the discourse of sex and love as a natural exchange of intimacy, fluids and in the view of young people in Maputo, blood. Taylor (1990: 80) and Allen and Heald (2005) note the same from Rwanda and Botswana respectively, where condoms are seen to block the mixing of blood during sexual intercourse and thus disrupt the natural order of things. Anal sex is likewise considered an unnatural act, which would be incongruent with girlfriend.

> Anal sex … I couldn't do that with my girlfriend, but I could with a 'friend' … anal sex isn't good [for you] you could injure [the partner] and other things … with a 'friend', she's the one that is after me so she has to satisfy me [121]

Another male participant in the focus group cited a more egalitarian strategy in negotiating sexual practice in principal partnerships.

> What can be done with a friend can also be done with a girlfriend as long as you have a conversation … I'm with my girlfriend and I ask her to do something, a certain position … she can say no. With a 'friend' … she would say OK, let's try it … she might like it or she might not … it's like a test.

Men feel considerable pressure to perform within a relationship and do not want to seem dull. The potential for a girlfriend to talk about a man's sexual performance is strong incentive for men to act in strictly censured ways. At the same time, forthrightness on the part of the women to indicate her sexual preferences transgresses the acceptable sexual scripts defined for that relationship type. A constant tension of negotiation thus drives youth sexual interactions.

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[120] SSI #111T / 24 years old / ♂ / 12th class / out of school / sexually active
[121] FGD #713T / 18 years old / ♀ / 10th class / out of school / sexually active

> ... level of intimacy and perceptivity of two partners ... if it's just one of them that wants to do something, then that would be difficult ... because if she were to propose something to me that she likes, I'm going to refuse and then there would be nothing ... she would say that that guy [me] is bashful, uhuh ... in general, when a girlfriend is more of a freak [*frique*], more daring, you can't trust her ... the boyfriend has to be really active, he can't keep up ... there is a lot to learn [with her]. There are men that know these things ... and others that don't.[122]

In this last case, her forthrightness created a conflict for him. Rigid gender roles are at play here, he is expected to be all knowing in the ways of sex and she compliant and submissive. When these positions are reversed, the couple has entered uncharted waters. Will he react well to his partner who is more experienced than he? The only culturally acceptable contact in which this is permitted is if it were the first time he had sex and the partner was an older woman. The situation is just as threatening for her, since she may be labelled a survivor, or worse, beaten by her partner. Next, we will examine the case of the survivor for both men and women, which illustrates how the double standard of male hegemony exerts its power over those young people who do not fit well into standard gender roles.

## 7.3 The survivor

The survivor is an identity predicated on the two phenomena explored above, violence and the expression of sexuality as transgression.[123] The survivor serves as an important example of how gender roles are locally defined and mediated by young people in Maputo. The category is a classic moral double-standard found throughout the literature (Kitzinger 1995). Male survivors do not suffer the same moral umbrage as their female counterparts, highlighting the double standard of male dominated ideology. Female survivors are sexually aggressive women are negatively viewed by both men and women. The survivor takes these themes further by transforming sexual transgression into an identity.

> A survivor is an eclectic person, he doesn't have a specific type of music, only that he's always on something, either drugs or alcohol, he has a certain way of talking ... using a really cool language and words that you don't find in the dictionary.[124]
>
> In my neighbourhood there's a Rasta [Rastafarian] with braids, people call him a survivor, in the morning when he gets up he puts on his jeans in his own way ... he walks around singing ... everyone knows him but doesn't have anything to do with them ... he doesn't even fear the police.[125]

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[122] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active

[123] Survivor, or *sovaiva* in Portuguese, initially perplexed the research team until the word was identified as an English work associated with the Rastafarian counterculture found in neighbouring South Africa.

[124] FGD #713 / 18 years old / ♀ / 10th class / out of school / sexually active

[125] FGD #713 / 18 years old / ♀ / 10th class / out of school / sexually active

Before discussing the moral discourse around the survivor identity, I first demonstrate how the appearance of fitness (physical, social, and wealth) mediates categories of risk. The survivor is then presented as a moral category that challenges the boundaries of risk and identity.

### *7.3.1 Risk as daily struggle*

Risk shades most conversations with young people in Maputo. However, risk only has meaning within the context of the daily challenges young people face. The following extract uses the metaphor of theft and daily survival to explain why condoms are used or not. The example clearly demonstrates knowledge of the risks as well as consideration of the various paths one can take to avoid them. Nevertheless, the passage uses the metaphor of stealing from the market to explain the inability to use a condom.

> Sometimes I think about risking it … [imagine] a person goes a month without work, he doesn't do anything, he doesn't eat anything, and he passes a *dumba-nengue*[126], and there are lots of things for sale, you don't have any money to buy anything … would he rob [something] knowing that he would get caught? [You know] there is no possibility of escape … we all know the risk, there is no cure. We have to face it, but facing it and not being able to handle it, that's different. I want to find some way out.
>
> So … you are really hungry and you pass in front of the *dumba-nengue* [informal market]… you grab something to eat … you haven't eaten since yesterday and if you risk it … you know that you won't get out of there alive … you could always say you did it because of hunger and get off, but in the case of AIDS, who is going to let you off? For example, in my neighbourhood there are girls that you see and [say] this one, use a condom … but there are others [girls] … she would just refuse and man what can you do?[127]

Similar sentiments were expressed in individual interviews. Many young men use condoms opportunistically, only if they are pushed to do so. Despite the intent to use them, if he encounters resistance by his partner he will likely not use a condom with the exception of commercial sex. Demands by a woman to use a condom with her boyfriend are likewise met with resistance, ostensibly in the form of mistrust that she "has some kind of disease [STI] and doesn't want to [say]." Even if one's friends use condoms, it does not automatically translate into condom use for others. When the same respondent was asked "Why [do] your friends use condoms but you don't?" the respondent felt confident that he has taken an active decision in reducing risk because "I don't just look at someone and then have sex with them." If a girlfriend insists on using condoms he will, but "if she doesn't ask [me to use it], I'm not going to."[128]

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[126] labyrinthine informal outdoor market selling foodstuff and small consumer goods
[127] FGD #715T / 22 years old / ♀ / 9th class / out of school / sexually active
[128] SSI#405T / 18 years old / ♂ / 7th class / in school / sexually active

### 7.3.2 *Risk categorisation: Familiarity begets safety*

Appearances contribute greatly to risk practices among young people. While young people know that appearance does not indicate someone's HIV status, moral judgements about worth, cleanliness, and attractiveness nevertheless determine safer sex practices. Participants focus on three dichotomies when making judgements about a prospective partner: rich/poor, good family/not a good family, and healthy/unhealthy (skinny/not skinny). Wealth indicates class, propriety, and desirability. Family background is a class marker which indicates respectability and wealth. Physical state signifies wealth as well as potential signs of illness due to HIV. Respondents readily acknowledge that "… even if you knew that she is a good girl [*filhinha boa*], and lives in Sommerschield … 'ehe' … she could have it [HIV]."[129, 130]

Wealth is perceived not only as an indicator of low potential risk, but also desirability. A focus group participant expressed this conflict by choosing between a girl from the elite neighbourhood of Maputo and someone from a poor *bairro*. The choice to use a condom with both of them provoked some disbelief among the group participants. However, the underlying motive for using a condom differs may be based on divergent perceptions of risk. Both could be HIV positive, but the purpose of using a condom differs among the two. To the participant, condom use signifies a protector role with the younger, richer girl – i.e. she is worth protecting, while the older, poorer woman is someone whom he must protect himself against.

> Let's assume that a 16 year old girl who lives in Sommerschield and you have another, not really a girl, someone of 22 or 23 years, someone who is already experienced [sexually] from the *bairro* [shantytown]… the girl from Sommerschield … because of appearances … she's younger, and rich, from a good family … but it really depends [on preference] … I could like the other girl from the *bairro*. If it is to have sex with one of them, [I would use a] condom with the one from Sommerschield. [laugh] … with the older also, I think it's good to be safe.[131]

Appearance is a proxy indicator of health status, and secondarily wealth. Someone from a rich neighbourhood "is less likely to get sick because she's rich … she can be really skinny and still not have the virus…" However, the same respondent qualified that assessment. "The next day you could be with someone who is much heavier [than the rich girl] and also well off, and she could have the virus …" In contrast, another focus group participant de-linked the association of physical status and wealth, stating "there are girls that you look at who you fear might be [HIV positive ] … only for being skinny … nowadays there are so many kinds of

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[129] Sommerschield is an elite neighbourhood of Maputo.
[130] FGD #715A / 22 years old / ♀ / 9th class / out of school / sexually active
[131] FGD #715A / 22 years old / ♀ / 9th class / out of school / sexually active

illnesses, you can get really skinny if you have a bad bout with malaria … at the same time she might be really pretty and she could have AIDS."[132]

> Appearance [is] tricky … if a pretty girl comes up to you at the disco and shows you some leg … you go crazy for her… as long as she looks well, you don't know if she has AIDS. But the symptoms don't appear for a long time after infection, so you never know.[133]

Despite accurate knowledge about the relationship between appearance and HIV, men in this focus group portrayed themselves as helpless to resist the biological urge to have sex. The perception that one can judge a person's HIV status by looks, gives men an excuse not to make appropriate plans to use a condom. AIDS prevention messages address this issue since preparedness to negotiate the use of condoms is a form of self-efficacy. However, "at that moment [of sexual intercourse] they forget all that … it's because they don't make a plan to use a condom … you have to put it [the condom] by your headboard so that it doesn't create an inconvenience."[134]

In response to the perceived biological imperative to have sex and the possibility that delay may risk losing the opportunity, men tend to ignore the risk of HIV/AIDS. They will rationalise the risk as low because "she is from Ponta Vermelha or Sommerschield [elite neighbourhoods] … she doesn't go out [with] lots [of men] … [or] she's a friend of the family [respectable]. You wouldn't even think of using a condom … if she's introverted you know that she could never have AIDS. It wouldn't even enter my head that I should use a condom."[135]

This rationalisation, however, is tempered by appearance and perceived worth. Few would forego an opportunity to have sex. "If a woman says to me, I want to go out with you, I'm not going to turn her down …" At the same time, "if she looks like she's one of those [less attractive] girls that sells *bagias* [fried snacks] on the street, I'm going to use 3 or 4 condoms."[136]

The prospect of sex with an attractive woman is more than many of the young men interviewed could contemplate losing. In part this may reflect the lack of opportunity to have sex reported by many younger men. "There are girls so beautiful… that when you look at them … they can't have AIDS … given the opportunity I'm going to take it. … Sometimes I just

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[132] FGD #715A / 22 years old / ♀ / 9th class / out of school / sexually active
[133] FGD #715A / 22 years old / ♀ / 9th class / out of school / sexually active
[134] FGD #715A / 22 years old / ♀ / 9th class / out of school / sexually active
[135] FGD #715A / 22 years old / ♀ / 9th class / out of school / sexually active
[136] FGD #715A / 22 years old / ♀ / 9th class / out of school / sexually active

risk it … there are girls who are really daring… they'll say, hey there, I like you, let's go outside. You don't resist … out you go … without a condom"[137]

The female survivor provides an important outlet for men to have casual sex, particularly when their girlfriends may be unavailable. Sex with a survivor also avoids the stigma and cost associated with commercial sex. Kitzinger (1995:189) identifies a similar personae in the UK, the slag, which exists in part because it fulfils a function of reinforcing the virgin/whore dichotomy. The slag is used by some women to buttress themselves as superior to others. It labels "others as cheap in order to assert their own value with the sexual/marriage market place". If the slag didn't exist, Kitzinger asserts that "she would have to be invented". The moral ambiguity of a survivor makes her more acceptable than a prostitute. The survivor can be considered a person, whereas a prostitute is an object to be pitied. In the same way, perceived notions of fitness mediate young people's perceptions of risk, and defined in terms of physical, social, and moral characteristics. As we have seen, a good girl is safe because she cannot have HIV. This phenomenon applies equally to men and women (Ramos, Shain and Johnson 1995). Coming from a well-to-do family from an elite neighbourhood also serves as a proxy indicator of safety. Lastly, how someone looks, both in terms of whether an individual looks healthy and importantly whether that individual is particularly sexy, impacts greatly in rationalising away sexual risk.

### *7.3.3 Moral discourse of the survivor*

The characterisation of a male survivor as a positive stereotype contains an element of rebellion and resistance to rigid gender roles. When turned toward women, especially those that aggressively assert their own sexual identity, men are much less accommodating. Men articulate a very definite moral discourse around what a good woman should act like.

> There are women that have no respect and spend most of the time out, they do what they want, they have no respect for others at home, they're not a part of society anymore … a 'good woman' is respectful at home, she goes to school, she knows when she ought to go out and when not to, you know? A normal girl [*miúda*] doesn't do this, she can still go out every weekend, go out with her boyfriend, with her brothers, but you know what she's going to do after the music [is over]…
>
> Women shouldn't be aggressive like that, it's different for a guy, there's a greater sacrifice, more violence [*porrada*] with him, now with a woman it's not, it's an ugly life.[138]

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[137] FGD #715A / 22 years old / ♀ / 9th class / out of school / sexually active
[138] FGD #803 / 19 years old / ♂ / 9th class / out of school / sexually active

The term survivor can be equally applied to men and women, although it has very differing meanings for each gender. As applied to women, a survivor is "a girl that hangs around with a gang of guys … they're drugged … a girl that infiltrates in there is a survivor because if she's with them always she's going to smoke [cannabis] with them."[139]

> They [women] like to create confusion, they act like men. A woman can find some guys sitting there and talk with them like a man [with feigned violence and insults] … and talk as if she were a man, to the point that men accept her as if she were one of them. [they] go to parties uninvited and they get there and create confusion.[140]

The characteristics which make women less desirable, or morally suspect, make a male survivor more attractive – he disrespects authority, uses drugs, and has many sexual partners. Women characterise male survivors as *Rocks*, which is the archetype of cool.[141] His anti-social traits add to his allure. It is the transgression of normal social and gender roles that makes him more attractive.[142]

> *Rocks* is a guy that wears dirty jeans and he's super cool. A girl would want to date a guy like him rather than some calm type who is too timid. We call those types dull and in order to not feel left behind, we prefer to hang out with this [cool] type. He is kind of a 'collective' partner. A collective partner is someone who has more than 2 partners [at the same time].

While Rocks may be idealised, women also see him for what he is, a potential source of risk. He's not someone who is interested in a long term relationship "... [they] are irresponsible. … you always [have to] use a condom. [143]

Men apply the same negative moral discourse to other men seen to transgress from the dominant heterosexual script, which consists of sexual conquest for men and passive acquiescence by women. When asked about male survivors, the conversation turned negative and condemning.

> there are [male survivors] … they have the same ways as the women, they don't differ that greatly … male survivors look for married women who have things … they go to '*Tia Marias*' for example [wealthy women] … *maricas* [gays] are an example of male survivors, despite being gay, they're still men, so these *maricas* what do they do, they find men to satisfy who give them money, it's the same as homosexuality … [144]

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[139] FGD #803 / 19 years old / ♂ / 9th class / out of school / sexually active
[140] FGD #803 / 19 years old / ♂ / 9th class / out of school / sexually active
[141] Rocks (*Roque*) is the name of an individual (possibly from a Brazilian television soap opera popular at the time of fieldwork) which has been extended to all male survivors emulating this style. Here it is meant as a generic description even if referring to a specific person.
[142] FGD #803 / 19 years old / ♂ / 9th class / out of school / sexually active
[143] FGD #707A / 18 years old / ♀ / 10th class / out of school / sexually active
[144] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active

### 7.3.4 *Survivor – girlfriend, freak, whore*

As a potential girlfriend, a survivor is not an appropriate partner, but may be suitable for casual sex. Laub, Somera, Gowan, et al. (1999:197) labels these gender roles as binary categories: "stud/fag" for males and "virgin/slut" for females. These categories represent rules of the game that limit gender roles and standards for sex and sexuality in the US context. Similar categories of moralised gender roles have been documented in other contexts (Kitzinger 1995; Eyre, Davis and Peacock 2001). In Maputo, this script would be survivor/*matreco* for men and virgin/survivor for women. The survivor typology holds diametrically opposite positions according to gender. Significantly, the inversion of the typology from positive to negative differs from the similar case of male versus female slut found in the Western context. The difference is the survivor identity is not solely defined by sexual practice, but consists of a complex construction of style, language, and identity.

> ... you really need to know who she is, you have to see the person's attitude ... even with someone that you don't know, you look at the constitution of a person ... if you date [namorar] her, you see the girl is a freak [frique] ... you see that she's well lived, you have to control her, she's got to be in the house by 7PM, or in one way or another, her behaviour has to please me, from there trust will come over time. [145]

Nevertheless, men continue to seek out sex with a survivor. She is sexually available, attractive, and lacks inhibitions. On the other hand, with a girlfriend, certain kinds of sexual practices are taboo. This does not apply to a survivor. This categorical division works superficially, but the boundaries often become blurred. For instance, one of the two might wish for the relationship to become more serious and the other will resist. Sometimes it is she who is reluctant.

> "... there are some really pretty survivors, you might want to stay with her but she won't have it anyway, even if you propose to her many times." Often times it is the man who is unwilling to challenge conventions publicly. ... it is really difficult to trust a girl the first day you meet her you go to bed with her ... and wherever you go with her people will know and start to ... it's really difficult to bring a survivor [or girl from a disco] home to your house ... you start to think, if today if I do this and she comes to my neighbourhood [zona] it's going to be worse, I'm a wimp (*moleza*).[146]

A survivor cannot be categorised as a prostitute because she doesn't always want something in exchange.[147] This flaunts the norms regulating transgression and forms a lever for a woman to define her own role that is sexually extroverted but not commoditised. It is she

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[145] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active
[146] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active
[147] Although many times there is an implicit exchange and the practice often constitutes transactional sex.

who controls the terms of her sexual expression and thus challenges men to adapt to her sexual scripts rather than follow staid gender roles. To pick up a survivor "you have to be there as if you're trying to conquer [win over] her … buy her some beers … or dance with her … a survivor [does it] on a whim while a prostitute [is] for necessity." A man does not need to conquer a prostitute but he must, in one way or another, win over a survivor either through skill or by force.[148]

> A survivor is worse [than a prostitute], she's just looking for [casual] sex, just for that day … now a prostitute isn't looking for [a relationship], and someone could take her out of that life. A survivor no, you might want to take her out of that life but she won't accept, she wants to continue with that life that she had, that environment of always being with this one or that one.[149]

One focus group participant recounted an important morality tale from his neighbourhood about a survivor who refused to give up the life. Her family did everything in their power to get her to settle down. They built her a house and set her up in it. She defied their wishes and continued to live the life of a survivor. For the study participants, this behaviour defied logic. The participants in the group had more sympathy for a prostitute than a survivor, since prostitution was justified as an economic necessity.

> … it's different from prostitution, [when] she leaves the house you know where she's going to make her money. [A survivor] doesn't go there, she goes to the discos or *barracas* [informal market stall/bar] and you buy her a beer … you can have her if you want … but when your money is gone, she leaves you and goes with someone else, it could be up to 3 or 4 people at the same disco.[150]

The group widely condemned the survivor who engaged in sex for favours because her boyfriend did not buy her things "like chocolates …. man, [she] changes boyfriends like changing a pair of pants."

> […] A survivor is one of those types you pick up at the disco … she's almost wild … almost a *vadia* [prostitute] … if you go to a disco and don't find anyone you know there, but you see this girl and it's not the first time you've seen her, so you get to talking [*cai no papo*] and then … [pick her up] … they lead a strange life, some just lose nights in the discos.

Another focus group participant recounted an experience he had at the Maputo Fair Grounds.[151] He was hanging out and a girl appears. He bought her a beer and then she would not leave.

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[148] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active
[149] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active
[150] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active
[151] The Maputo Fair Grounds (*Feira Popular*) is a well known youth hangout, consisting of arcades, restaurants, bars, and strip clubs.

> ... she stays there and hangs out with you until 10PM or even until 3AM, then she pushes you because she knows that maybe she'll leave with some fifty thousand [*Meticais*].[152, 153]

As in neighbouring South Africa, the simple act of purchasing a beer for a woman can be construed as buying sexual favours (Wojcicki and Malala 2001).

As we have seen, the female survivor represents a troubling category for young people in Maputo. The identity resists categorisation which makes the survivor more dangerous than a prostitute because she can't be labelled as the other. Another troubling aspect of the survivor is proximity. She could be one's sister, daughter, cousin, or neighbour. The survivor cannot be socially isolated as a prostitute can. The real problem for men is that in some ways the survivor is a desirable partner, while a prostitute would rarely be considered as such. A survivor might be quiet and demure at home, "but 3 or 4 blocks from there, she's another person."[154]

While a survivor maybe desirable by some as a secondary girlfriend, she could never be considered a candidate for a main girlfriend. To be socially fit as a main girlfriend, she must be respectful, dignified, and educated. A dignified person "thinks first about herself, then about the future". Furthermore, she must present herself well, but not show off. It is not something that happens by chance; one is "born with that character".[155] The next passage is instructive in how social roles are deeply embedded in discourse. The respondent began describing what makes a desirable partner, but then switched gender (which is very specific in Portuguese) and finished by describing a proper man. Even more important, he demarcates a boundary in which a survivor could never cross. To be dignified one has to be born into it, or it must be passed down from one's family. As one respondent put it ...

> It reflects one's education at home ... poor behaviour can come from the home because the father is absent and then appears at 5pm and starts screaming profanities and the children learn these ... there's a tendency for children to pick up the negative ...[156]

This discourse on a proper man/woman describes the antithesis of a survivor. A survivor thinks only for the moment and has no plans for the future. A proper person thinks first of herself and then to the future. A survivor is unaccountable, irresponsible, and unpredictable.

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[152] The Maputo Fair Grounds (*Feira Popular*) is a well known youth hangout, consisting of arcades, restaurants, bars, and strip clubs.
[153] About US$ 5 at the time of the research activity.
[154] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active
[155] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active
[156] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active

> ... her life is only to *'curtir'* [have a good time], she doesn't want to know about anything else. ... all she has is the disco. She doesn't respect her parents, she does what she wants ... She could go out with the intention of doing one thing and then end up doing something completely different ... if a guy stops her, right there, she drops everything and hangs out with him ...

As the next passage indicates, the survivor's lifestyle may ultimately limit compatibility in a primary relationship. In this case, the respondent describes through another morality tale how a woman who is sought after for marriage may choose to live outside the rigid gender norms imposed by men. In effect, it blames her for choosing to live an alternative lifestyle.

> I know a girl who was proposed to by 5 guys and she said – 'if I marry you tomorrow I can't go to the discos. I can't marry you because they're still going to open many more discos and I won't be able to go because I'll be at home with you. I want to go those discos and after they close all those discos, then I'll be able to marry you.' ... hey it's difficult to stay with a woman like that.[157]

The use of the survivor as a moral category is even more insidious than a simple good/bad dichotomy. A survivor can play one role during the day – the sweet girl next door or quiet classmate – and then at night she is a disco queen. For the men interviewed, this is a form of betrayal because the survivor can have both worlds.

> ... by Friday night after 5PM she just changes ... she's not the same girl that you might know from school for example, you see another person there. So if she lies and says it's the first time she's ever seen you, then you know she's a survivor. She knows ... there's nothing to say ... one weekend she's with this one, and another she's with you ... the next day you pass them on the street and you don't even know them.[158]

### *7.3.5 Sex with a survivor*

As previously noted (Section 7.2.2), study participants reported that certain sexual practices are acceptable to perform with their girlfriends and other practices are not. A girlfriend may not be available sexually for several reasons, including prohibitions on sex during menstruation due to the polluting nature of menstrual blood; during her fertile period the couple may choose to abstain; post-abortion or post-partum abstinence; or one or both partners is travelling or away for an extended period of time. To experiment sexually, younger boys have few options available to them. They can visit a prostitute, but this requires money and access to areas where prostitution is available and affords some anonymity. The difference between the two was described as such: "with a prostitute you don't have time for caresses or kisses and these things ... for me a girlfriend demands more attention, tenderness, kisses, and

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[157] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active
[158] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active

sensitivity."[159] A survivor is an alternative somewhere between a girlfriend and prostitute. She is treated with the same distance and discretion as a prostitute, but the relation tends to be more intimate and personal.

> I'm not going to do the same thing with a prostitute as with a survivor or with my girlfriend. You know, many guys have been there [with the prostitute] before and sometimes she does not take a bath, you do not go pass your tongue there …
>
> A girlfriend, first and foremost, has to be your friend … you have to be able to explain anything, know what she likes … you talk about things … you have conversations like that … you can't do something without the consent of the other … there's no lack of respect.[160]

Even with a survivor, there is considerable pressure on the man to perform and to meet the expectations associated with the partner type. The pressure in this case is ironic, since a survivor is an experienced woman with low inhibition. The man must match and exceed this to comply with the normative role as a sexual expert.

> I had a girlfriend that didn't like '*apanha moeda*'[161] … … I respected her because I liked her [and] I had to respect her. But some girls get more pleasure from *apanha moeda* … some like this position and others do not. Survivors, man, girls now like craziness … you know … if you don't do crazy things with them, along comes another guy, and hey, there they go and they don't look at you again.

The sexual scripts associated with conservative gender roles, such as that of a main girlfriend, preclude the sexual experimentation cited above. In contrast, the proposition and adaptation of conservative sexual scripts with a main girlfriend poses considerable problems for a couple. Some are better suited to negotiate these situations, akin to Ingham and van Zessen's (1997) framework of interactional competence while others are less skilled. The following example demonstrates how script theory helps to organise such complex negotiations. In this case, it is the woman who proposes a new sexual position. Much of the negotiation is going on in their heads as intra-psychic scripts; however we only have insights into his thinking in this case.

> … it depends on the level of intimacy and understanding between the two, if I'm a person that only likes to do things that I know, it's going to be difficult, she's always going to propose things that she likes. … if I refuse she's going to say that guy is stubborn … if your girlfriend is 'freaky' she is untrustworthy … [you wonder] where did she learn that … some men don't even know things like *minete* [cunnilingus].

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[159] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active
[160] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active
[161] *Apanha moeda*, [pick up a coin], refers to vaginal sex from behind where the woman bends over as if she were picking up a coin from the ground. Also referred to as *traseira* (back/behind) which may also be anal sex.

> At the same time, [if] she wants to be with you, she is obliged to learn. She has to balance [between] experience [and innocence] ... I don't know what a *minete* is and she asks me to do a *minete.* What is this *minete*? She then explains it to me, now in my mind [I'm thinking], where did she learn these things?

When the woman is more experienced than the man, both find themselves in a difficult predicament. For him, having someone sexually experienced may mean a more gratifying sexual experience for him. However it also means that he must accept that she learned these things from someone else. It may be that she saw them in a film, but even so, he may be quite sensitive to the fact that she is more knowledgeable than he. "She can't just say give me a *minete,* there's got to be some soft talk that I want that [position]."

Despite the advantages of she being more sexually experienced, there is great reluctance by the man to accept that she may be more advanced than he. A girlfriend must still conform to certain conventions. The man must respect his obligations and take her out, but never the other way around.

> The girls we like are those that are daddy's little girl ... everyone wants a girl like that ... those girls that like it from behind [anal sex] and you suck her [cunnilingus] ... ... how are you going to know that she likes that? ... to like anal sex, she has had to have done it [before] ... how does she know she likes it, she saw it a film, hey ... she's had to have experimented with it ... a person that likes these kinds of things has to be a survivor.[162]

### *7.3.6 Condoms with a survivor*

In the last section, we considered the definition of a dignified person as one who presented themselves well, but humbly, and they considered the future implications of their actions. The survivor is regarded as someone with whom condom use is necessary in the same way one would use a condom with a prostitute. The problem with linking condom use with the survivor is the fluidity of the category. As we have seen, a survivor can be a desirable sexual partner precisely for the reasons that she is not dignified, she lacks inhibitions, and she thinks only for the moment.

> Sex with a survivor? You use condoms ... yes [all AGREE], you just use them, there's no conversation about why ... If not, no, you don't risk it ... it's just that, sometimes you don't have a condom ... there are some that do that ... it depends on the person ...but, if it's one of them [a survivor] you don't risk it ...

Here again, appearances can be deceptive and men use a complex process of rationalisation to decide if they should use a condom or not. Male gender roles dictate that a man should never forego an opportunity to have sex. This is compounded further for young males, since they have fewer opportunities to have sex due to cost, status, and lack of place to

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[162] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active

have sex. Faced with the prospect of losing the chance any minor impediment can result in non-use, such as lack of access to a condom at that moment or if appearance deceives one into thinking that she is not sick.

> There are [girls] that when you look at her ... and you want to *bazar* [have sex with her], you ask your friend for a condom ... at least one of them will have a condom ... With a survivor you never know is she's sick or not ... [but] nothing ventured nothing gained[163] so you take the chance ... lately you can't count on that, what counts more is appearance ... if you go by clothing it won't tell you anything ... she can trick you to see scenes like that ... because shit, if a '*macanana*' [164] shows up dressed like that, ah, shit you go right to it ...[165]

Finally, just as we began this discussion of the survivor with the issue of categorising risk, condom use with a survivor is also mediated by the same phenomenon. Familiarity or closeness obscures the categorisation of a prospective partner as risky. "When it's a girl in the next class you can see what kind of life she's in." Otherwise one cannot evaluate her behaviour and the only option reported was to use a condom. Some expressed regret in not having used condoms. "Sometimes you have a condom but you don't want to use it, but this is your problem if you buy one and then feel uncomfortable using it.[166]

## 7.4 Conclusion: Sexual risk in context

Sexual scripts serve as a useful organising framework to understand how condoms are negotiated under various scenarios. However, these scripts are meaningful only within the boundaries of the contexts put forth by young people themselves. The scripts identified help to uncover the gender ideologies which dictate gender norms and roles in a given context. The survivor identity shows how these boundaries are defined, maintained, and negotiated. The negotiation of identity around the survivor reflects the gender ideology and norms that each participant brings to an encounter, and influences the options for HIV/AIDS prevention. While a myriad of social and developmental factors shape such interactions, a limited set of options are available to young people. The standard ABC of HIV/AIDS prevention – abstinence, be faithful, and use condoms – is the starting point for any discussion of prevention practice. Under this regime, condom use is predicated upon individual agency. Instead of a simple linear outcome of condom use, if not 'A' or 'B' then 'C', abstinence and faithfulness are fused into a meta-category of partner selection which undermines the imperative for condom use.

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[163] *Quem não arrisca não petisca.*
[164] beautiful woman
[165] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active
[166] FGD #803T / 19 years old / ♂ / 9th class / out of school / sexually active

Where does the survivor fit within the ABC framework? To most young people, the answer would be an emphatic A or C, and definitely not B. The survivor identity fulfils a need to break out of the rigid roles young men and women find themselves in. While the cost of transgression is high, for men it is acceptable but for women it is not. The transgression of gender roles which she embodies cannot be accommodated.

The sexual scripts presented in this chapter illustrate how context and discourse shape youth sexual practice and risk behaviour. Factors such as risk perception, gender roles, and social learning lead to rigid interpretations of safe sex. Awareness of these behavioural patterns, while prevalent among young people in Maputo, does not translate into protective practices across contexts. Appearance can drive risk practices despite the commonly held notion that one cannot tell if someone is HIV positive by looking at them or by other superficial characteristics like wealth. Gender, likewise, suggests limited variability in the roles men and woman can express in the context of relationships. Strong sanctions regulate these roles, although deviation from them was noted. Social learning of gender roles unveils how young people come to acquire risky sexual practices and suggests potential avenues for supporting social networks to influence protective practices, a topic which will be discussed in the context of policy implications in the overall conclusion of this thesis. Lastly, the safe sex discourses expressed are placed in a larger context of risk. Life in Maputo is precarious and risky, sexual risk is just one of the many risks an individual must cope with.

The next chapter focuses exclusively on how young people combine the need for sexual experimentation with risk reduction practices. The chapter presents the case of the *saca cena*, or one-night stand, as a further variation on the improvisations we saw at the end of this chapter. Young people go to bars to *curtir* and to have sex, but not all put themselves at peril in doing so. While this innovation does not eliminate the structural impediments to behaviour change such as economic dependence, the combined weight of innovation may well alter the social norms that drive high risk sexual behaviour. Moreover, understanding the process of innovation may well assist future interventions to influence behaviour change.

## 8 THE *SACA CENA* : PRACTICE RECONSTRUCTED

The *saca cena* is a one-night stand which consists of casual sex with an unknown partner met at a public venue such as a bar, disco, party, or chance encounter on the street. The practice is bound by a set of implicit rules emphasising anonymity, discretion, verbal and nonverbal cues, and for some, explicit condom use. While a marginal practice reported by only a small segment of urban youth, from the perspective of behaviour change it raises important issues for intervention agents and policy-makers alike. Is the practice a new source of risk for young people or an existing practice altered to accommodate new meanings of sexuality, gender power relations, and social interaction?

For young men and women in Maputo, the performance of the gender roles seen in the *saca cena* reflects an important de-linking of risk assessment and partner characteristics. In Chapter 6, I examined how condom use is driven by assessment of partner characteristics – do I know him/her, do I know his/her family, does she/he have money, and what does she/he look like? Risk practice is counter-balanced by another local category of practice explored in Chapter 7, the survivor, an individual with no responsibility or concern for the implications of his or her actions. Casual sex and the non-use of condoms are typical elements of the survivor lifestyle, which also consists of spending every night at the discos, hanging out with friends, and disrespect for authority. The *saca cena* shares the same *joie de vivre* but chooses to mitigate the risk associated with the survivor lifestyle by practicing safer sex. Young people are exploring the boundaries of gender roles by reversing some of the power dimensions found in safer sex, and as a result have contributed to a disconnect between perceived risk and partner type, leading to the incorporation of condom use as part of the *saca cena* identity. Risk assessment by superficial categories is made irrelevant because to *saca cena* is to use a condom.

To explore this phenomenon, I explain what the *saca cena* is, and how it has become embedded in the discourse and practice of sexual scripts among Maputo youth. I show that innovation – in this case the use of condoms during a *saca cena* – is facilitated by the successful negotiation of a moral discourse around what is an acceptable and unacceptable risk. Finally, I demonstrate how the *saca cena* has reconfigured power relations between men and women in subtle but fundamental ways. The *saca cena* challenges the dominant discourse of sex for procreation, economic security, and emotional intimacy while providing an important outlet for male and female expression of sexual desire and pleasure. It does so while mitigating the

threats associated with such practices including damage to reputation, the break up of stable relationships, and STI or HIV exposure.

The one-night stand which has been an important topic in the literature on youth reproductive health from the perspective of risk practices and predisposing attitudes (Leigh, Aramburu and Norris 1992; Lottes 1993), but to a lesser degree in terms of actual sexual practices (Feeney, Noller and Patty 1993). The literature focuses almost exclusively on coital activity and not those resulting in non-coital outcomes (Wright and Reise 1997) which reflect the range of sexual and relationship behaviours of young people. Public sex venues afford a sexual interaction that is impersonal, anonymous, and emotionally detached with few entanglements (Flowers, Marriott and Hart 2000). A public sex encounter is easy, requiring minimal time, effort, or cost on the part of participants. The risk associated with public sex is minimised by controlling the context (where possible), but what danger exists may provide excitement and variation that contributes to the erotic experience (Tewksbury 1996). Kroll (1990) comments the negotiation of these rules represents less of a sub-culture than a microcosm of the same social rules which govern the rest of society.[167]

While the physical characteristics of a public sex setting often determine the kind of interaction that takes place, more applicable to the question of innovation is how the rules of the game are elaborated. In effect, by deconstructing sexual practise, we can reveal a set of rules of intimacy. The rules may be location specific, such that characteristics of the setting or institution impart meaning and structure on sexual activity. For instance, sex in prisons serves as both punishment and pleasure (Dowsett 2004). Instead, informal communication and rules consisting of cues, symbols, language and gestures are acted out, reminiscent of Goffman's performance (Goffman 1959) and Bourdieu's habitus (1990). At the same time, this interaction is fluid and dependent on both the social as well as physical environment. A degree of improvisation and experimentation is incorporated into a flexible framework that allows the interaction to take place.

As we saw in the previous chapter, reputation plays an important role in regulating sexuality and gender relations, especially in terms of condom negotiation. For men, sexual

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[167] Lambevsky illustrates how cruising in Skopje, Macedonia carries the burden of ethnic tensions between ethnic Albanians and Macedonians, noting how larger power relations determine the rules and interactions of the cruising venue (Lambevsky 1999). Considerable consistency in public sex venues is found across societies: including Australia (Dowsett 1996), England (Keogh, Beardswell and Research 1997; Flowers, Marriott and Hart 2000); India (Asthana and Oostvogels 2001); The Netherlands (de Wit, de Vroome, Sandfort et al. 1997); and Thailand (Jackson 1997; McCamish, Storer and Carl 2000).

adventurism enhances one's status while for women it detracts from their moral value. Rather, it is the establishment of new boundaries and the shaping of existing ones that gives innovation meaning. For women, transgression can mean loss of reputation with the potential of being labelled the moral equivalent to a slag (Kitzinger 1995). At the same time, it can be an avenue for the expression of unconventional gender roles by female participants. The struggle for moral status is centred on control over women's reputation as good girl versus bad girl. Absent from this categorisation is desire and the powerful woman, confident in the pursuit of her sexual and social desires now and in the future. The *saca cena* fulfills this role for women without overtly threatening traditional masculinities.

## 8.1 What is the *saca cena*

> "A *saca cena* is someone who you don't know and everything you do with [him or her] doesn't go beyond that day."[168] ... [He is] a type of collective partner ... that has sex with one or more persons. ... It's [all] the craze now.[169]

The *saca cena* consists of casual sex with an occasional partner, often a stranger or casual acquaintance, at a public venue. The *saca cena* might occur at venues such as a bar, disco, or party. Regardless of the setting, a *saca cena* is bound by a set of implicit rules based on anonymity, discretion, and experimentation. The term literally means to take the scene, to go out and have a good time, with the scene referring to either a particular event or generically as a social situation. A *saca cena* may refer to the person or to an act, similar to the way US university students "hook-up" – a single sexual encounter between two people who are strangers or brief acquaintances, which usually but not exclusively ends in coitus (Paul, McManus and Hayes 2000:76).

The *saca cena* is a new phenomenon and coincided with the rise of youth *curtidor* culture of hip hop, clubbing, and general opening of Mozambican society in the post-war period. Prior to multi-party elections in 1994, Maputo could be considered in many respects a garrison city and rigid social control precluded the emergence of open forms of night life. The opening up of society after the 1994 elections fostered a wider process of democratisation which led to a vibrant nightlife among Maputo residents. The rise of the *saca cena* evolved from this scene between the period of 1995 and 2000. Young people took their social and fashion cues from neighbouring South Africa and from further a field including Brazil, Portugal, and the US.

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[168] FGD #702T / 16 years old / ♀ / 9th class / out of school / not sexually active
[169] FGD #707A / 18 years old / ♀ / 10th class / out of school / sexually active

Just as HIV/AIDS coincided with the rise of democratisation, so too did new forms of sexual identity. The *saca cena* is a product of this new modernity.

The *saca cena* refers to casual sex without emotional commitment and the participants may or may not know one and another. The setting and location play an important role in defining the sexual script practiced.

> A *saca cena* is when a guy and girl have sex in 1 second, but without any commitment. [He] is my secondary [partner] ... [and] for him it's a *saca cena* also. He's not a regular boyfriend for me.[170]
>
> A *pito* [friend] ... knows how to take you out ... to the cinema and that kind of thing – a little here and there. But a guy that says ... that girl was my *saca cena*, [he] only needed her for that moment. A *saca cena* only needs you at that moment when [his] girlfriend can't have sex with [him].[171]

While the interaction is sexual in meaning and intent, the possibility of a non-sexual outcome is an important aspect of many of the younger girls' representation of the *saca cena.* The pretence of a non-sexual outcome maintains a certain degree of innocence and self-protection, for them. In the following example, the young women in the focus group discussion were not yet sexually active but knew what the *saca cena* was and what it means. Even to those who have never participated in the practice know precisely how a *saca cena* is scripted, the expectations associated with it, and the likely outcomes of such an encounter.

> A *saca cena* might not come back, there's no commitment, you don't have his address, it stops there. A *saca cena* is someone you don't know and everything you do with him is of that day. It means ... I don't know how to explain [it], but ... if I'm at a café and a guy shows up, we talk and after, we can *saca cena*.[172]

The *saca cena* reflects the dominant double standard that young women face and thus cannot be considered a static category of partnership type. Like other contexts, women must protect their reputation, which effectively regulates their sexual and gender relations, especially around condom negotiation (Holland, Ramazanoglu, Scott et al. 1991). The *saca cena* is significant in tempering the sanctions associated with reputation by insulated women from social approbation. Within the confines of the *saca cena*, women find an avenue for the expression of unconventional gender roles including the expression of sexual adventurism, desire, and power.

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[170] FGD #707A / 18 years old / ♀ / 10th class / out of school / sexually active

[171] FGD #704T / 16.5 years old / ♀ / 9th class / out of school / sexually active. Due possibly to prohibitions on having sex during menstruation, during fertile period, postpartum, and post abortion ..

[172] FGD #702A / 16 years old / ♀ / 9th class / out of school / not sexually active

The management of different relationship styles also figures strongly in young women's use of the *saca cena*. The dominant cultural script of male sexual need and aggressiveness is met with a female script of guarded availability and inexperience. A younger girl is expected to have sexual relations with her boyfriend, but also seeks ways to secure the relationship with emotional ties – the have-hold motif referred to in previous chapters. While this fulfils an important function of mitigating the potential risks brought about by engaging in sexual relations with the boyfriend, it does not necessarily fulfil all of her expectations regarding relationships. Other relationship types may be sought out to satisfy these claims, such as those with economic benefit, a *pito* who offers companionship, or a *saca cena* who offers a purely sexual outlet.

> There are different types of partners, there could be *pitos*, *saca cenas*, 'part-times', husbands, lovers, and boyfriend ... it's he who you have an exchange of experience, conversation, and have sexual relations. You talk more with a [main] boyfriend about problems, pain, or sex. A '*pito*' is different from a boyfriend, with him you don't have sexual relations ... it's only kisses and long walks.[173]

For some women (especially those in school), the *saca cena* embodies a striking expression of change spoken about by young people when describing their sexual repertoire. The practice represents independence, the breaking of boundaries and establishing of new ones, experimentation, and instant gratification. Women can maintain different types of partners, each with different sets of expectations both in terms of emotional commitment and sexual practice.

The terminology for different partner types constantly shifts across groups and ages. As noted in Chapter 5 and above, a *pito* can be an innocent friend with whom a girl might exchange kisses or hugs, but is not considered a sexual partner per se. For others, the *pito* is a sexual partner with little emotional attachment, but fulfils an important need for companionship. While overlap between the categories exists, the crucial difference between a *pito* and *saca cena* is level of commitment – *saca cena* is someone who you never expect to meet again.

> A *pito* could be a boyfriend. You have sex [with him] ... they have the same needs as a boyfriend. You can have another partner [*saca cena*] in order to alleviate yourself sexually because you don't want to bother your boyfriend. A *pito* could be on Saturdays only to give [some] tenderness and not be bored. ... *Saca cenas* are different from a *pito*. With a *pito* you can go out to the movies with and a *saca cena* is just for sex. A *saca cena* is an instrument that you need just in that moment.[174]

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[173] FGD #704A / 16.5 years old / ♀ / 9th class / out of school / sexually active
[174] FGD #704A / 16.5 years old / ♀ / 9th class / out of school / sexually active

> Let's imagine that I have a boyfriend and then I have another relationship with another person, I call this other person my *saca cena* [or] a *vizinhança* ['neighbour' i.e. someone who lives close by with who you have sex] ... [the latter] isn't boyfriend and girlfriend, but they're friends. Now, a *saca cena* is just theft.[175]

Age as well as gender differences also mark divergent views on the *saca cena.* In the following interchange within a focus group of 18-year-old girls, the participants negotiate the meaning of a *saca cena* in relation to a stable relationship, arriving at a common understanding of the *saca cena.*

> ♀[1] For me to *saca cena* is to have an occasional [sexual] relation. I have a boyfriend and I go to a party and I meet a guy there, maybe because I like his body or something.
>
> ♀[2] That's not a *saca cena.*
>
> ♀[1] It is a *saca cena* because from there you never see me but because that scene is over. I'm not with my boyfriend and I'm alone, I'll *saca cena* because I like him and we won't even know each other. *Saca cena* is with various [guys], you go to another party and you find someone else.
>
> ♀[3] They [*pito*, lover, *saca cena*] are all the same thing.

The group eventually comes to agree the *saca cena* refers to casual sex without commitment, while reinforcing the practice with the legitimacy of a stable relationship.

> ♀[1] If I'm married and I go have an outside [sexual] relation with a man ... that man is my lover. I'm going to have sex with him more than once. Now with a *pito* it's the same thing, I'm going to have more than one contact with him, yes. [A *saca cena* is] a person that you meet one time only, you meet once and you take the scene.[176]

## 8.2 A *saca cena* script

Not all *saca cenas* are anonymous pickups. The following example is extracted from an individual interview (SSI #416) with a young man, 18 years old, who is still in school. The sexual interaction he describes gives some insight into the kind of intra-psychic script that each partner brings to the table. Due to ethical as well as practical constraints, the corresponding script of his partner was not documented. Nevertheless, the interaction lends insight into the forms a *saca cena* may take. In this case, the *saca cena* is a schoolmate. Once she becomes a *saca cena,* however, she can no longer be considered a friend and further interaction with her will be cut.

> My last sexual relationship was two weeks ago with a girl, also 18 years old. It was the first time I had sex with her. ... [My friend] told me there was this girl who likes me not as a boyfriend, but for a *saca cena.* He said that I had to be 'agile'.

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[175] FGD #901T / 21 years old / ♂♀ /10th class / out of school / sexually active
[176] FGD #707A / 18 years old / ♀ / 10th class / out of school / sexually active

> It happened at my friend's house. When we went there, it was with the intention of having sex, but she didn't know that. I asked my friend if he would let me use his bedroom and he said 'yes'. When we got there [to the house], my friend greeted us and then went away. We started to watch a film in the [living] room and then I said to her that we should go into the bedroom. We talked a bit and then we started to touch each other. I took my clothes off first, and then I took off her clothes. We had [vaginal] sex; we used a condom. It took about 30 minutes.
>
> [We had sex because ...] she liked me, but didn't like me as a boyfriend, only as a *saca cena*. I liked her as a friend, but we weren't boyfriend and girlfriend. She has a boyfriend, although I don't know him.
>
> The sex didn't really meet my expectations. From the way she talks and acts ... it wasn't as I had hoped. At that moment, I just wanted to have sex with her and after that I didn't want [to be with] her anymore. After, all I thought about was how to get out of there and forg*et al*l about it.

When asked why he used a condom, the respondent indicated that it was what one does. He didn't think about it at the time or "even say anything, [he] just grabbed the condom and put it on, she didn't object or say anything." When pressed why, he responded:

> Because since about 3 months ago, I began to hear a lot about AIDS, and I didn't have a lot of confidence in her ... I also thought about pregnancy, I don't know her cycle. I have friends that have kids by now and I don't want to have kids at this age.[177]

## 8.3 The rules of the game

> "A *saca cena* always uses a condom ... [she/he] has to use a condom."[178]

As we have seen in the examples above, girls talk about the *saca cena* in the context of regular partnerships, although men do not always reciprocate and view the *saca cena* as independent of a regular partnership. The rules of the *saca cena*, like the rules seen in public sex venues, are based on cues and language engaged in the negotiation of the activity. For a young woman, the framing of the interaction within the context of a stable relationship ensures her reputation as a respectable girl and makes it clear what is wanted out of the encounter for both parties – no future entanglements that would threaten the stability of her regular partnership.

> *Saca cena* is when you meet someone at a scene [party, place, etc]. You always say that you have a boyfriend, you make it very clear.[179]

This negotiation plays on dominant cultural scripts of opportunity and access as explored in Chapter 6. The male is always available and willing for sex while the female is not,

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[177] SSI #416A / 18 years old / ♂ / 8th class / in school / sexually active
[178] FGD #707A / 18 years old / ♀ / 10th class / out of school / sexually active
[179] FGD #713A / 18 years old / ♂♀ / 10th class / out of school / sexually active

although eventually she gives in. Importantly, the use of condoms is seen as the norm in these contexts, but remains the responsibility of the man to provide.

> It's [more common] for the guys to want to *saca cena*, not the girls. With a *saca cena*, you always use a condom. Guys, when they go to a party, their pockets are filled with condoms. You don't refuse [him]... [but] since you don't know him, you use a condom.[180]

The dominant sexual script illustrated in the following description of a *saca cena* demonstrates the male script of availability, dominance, and control in a relationship, while recognising the dependent status of the woman. She nevertheless requires emotional support and consolation for being used. Furthermore, the market of sexual availability is seen to favour men more than women, who have more to lose in terms of emotional investment and reputation, even during a *saca cena.* No regret is implied on the man's part, but it is assumed that she will have regrets unless given some emotional succour.

> For guys, it's really easy now ... they pick up [a *saca cena*] just to alleviate [themselves] because their girlfriends tell them to wait [a lot] ... Normally, a guy can have sex everyday, so he's with his girlfriend today and in order not to bother her, tomorrow he can go off with a *pita* ...If he doesn't want to talk, he can arrange someone as a *saca cena* ... [he might] want her on Saturday, so she goes to his house on Saturday and when she gets there he seduces her and she'll give in ... in the end, it's always that way. So with a *saca cena* you give a little affection, whatever, so that she doesn't feel you know, really bad, but she only serves for him to alleviate himself.[181]

Protecting the rules of the *saca cena* is crucial to the continued functioning of the activity. By engaging in the *saca cena*, both parties risk exposure and the possible dissolution of their primary relationships. Nevertheless, when faced with exposure, for instance if one is with her *saca cena* at a party and her boyfriend shows up, respondents agreed there is only one recourse.

> You find a way to make your *saca cena* understand there's a problem, you make a signal of some kind. You have to leave it [the *saca cena*]. I dance with my boyfriend, and if a *saca cena* came toward me, I'd shut up and pay no attention [to him]. If you go to him, he'd ignore you ... it's shameful.[182]

The complicity of the rules of the game extends to others engaging in a *saca cena* as well. The silence that surrounds a *saca cena* betrays a tacit distrust among partners. If one partner is engaged in a *saca cena* it is assumed the other is as well.

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[180] FGD #713A / 18 years old / ♂♀ / 10th class / out of school / sexually active
[181] FGD #704T / 16.5 years old / ♀ / 9th class / out of school / sexually active
[182] FGD #713A / 18 years old / ♂♀ / 10th class / out of school / sexually active

> Fidelity means ... to confide in one another and not to betray. When you pick up a *saca cena* and you're not with your boyfriend while he's with another, there you keep quiet, it's normal that this happens because some do it others do it. [183]

## 8.4 Morality and sexual favours

The moral discourse surrounding the *saca cena* is most evident when examining the economic motivations for sexual relationships. Considerable discord was noted among the study participants about the topic. Young women interviewed deemed the practice of sexual favours for gifts as an issue of diminishing self-worth, not as an issue of morality or transgression per se.

Similarly, the moral justification of the practice of *saca cena* is placed squarely in the court of gender power relations. Young women justify the exercise of their sexuality as a form of power to extract wealth from men, in counterbalance to men's use of the *saca cena* to engage in sex without emotional or economic commitment. Young women fail to recognise the true cost of intergenerational sex, the increased risk of HIV transmission (Barnett and Blaikie 1991; UNAIDS 1999a).

> Someone might like you and pay for your '*lanche*' [literally a snack, but here meaning material goods]. You only want him for his money, to pay [for things]. If they [men] can have *saca cenas*, we also have the right to have *xitlhacalanfundla* [sex for money]. [184]

> That's it, there's the motive ... [they go with rich men – *homem ricos* (*HR*)...] because I want to look good, and I go to [nice] places like that ... they call that a sponsor [*patrocinador*]. [185]

Leshabari (1997) notes the sugar-daddy phenomenon has become a catch-all for the moral outrage directed at male-centred African sexuality, making the case that moral transgression is emblematic of a more profound cultural shift in African societies.

> You can have your boyfriend and another intimate friend. There are girls who say that they have their boyfriend and a spare [*sobressalente* – spare tyre]. They are their *saca cenas*. They're practically their sponsors. You have your *saca cena* outside [of the main relationship]. The other is an intimate friend, the other is a boyfriend, in our case you have boyfriends and sponsor. It's the same thing; you can have two *pitos* at the same time. Often we have a sponsor usually an older man who 'invests' in you. [186]
>
> ...a *HR* has more, but ... the *HP* (*Homen Pobre* – poor man) prepares for the future for his girl. A *HR* can also prepare for the future for a '*pita*'. [187]

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[183] FGD #702A / 16 years old / ♀ / 9th class / out of school / not sexually active
[184] FGD #704T / 16.5 years old / ♀ / 9th class / out of school / sexually active
[185] FGD #707A / 18 years old / ♀ / 10th class / out of school / sexually active
[186] FGD #707A / 18 years old / ♀ / 10th class / out of school / sexually active
[187] FGD #901T / 21 years old / ♂♀ /10th class / out of school / sexually active

Young men expressed their dismay at their disadvantaged position in the market for relationships, drastically limited by the fact that they could not afford to buy things for girls.[188] Those criticising the practice posited their condemnation of sex for economic interest on the moral character of the woman in the guise of questioning her self-worth. She must consider less of herself if she engages in such practices, since it reflects selfishness and short-sightedness.

> I don't think that this is investing because what we called investment I think is caprice ... capricious to buy [pretty] clothes ... these [are] things only for today, not for tomorrow, it's not a secure thing. Security is not something a boyfriend can buy.[189]

Certainly there is considerable cross-over between the *saca cena* and the sugar daddy phenomena, however to conflate the two would not do justice to the saca cena as a sexual identity. First, intergenerational relationships associated with sugar daddies are marked by stark power differences between the two partners; the *saca cena* does not share this power dynamic. In the case of the former, it is the inequity of power in sugar daddy relationships that preclude women from negotiating condoms. Second, the citations given above demonstrate the need for men to justify women's actions as immoral because they challenge male hegemony in sexual relationships. This theme is further explored next.

## 8.5 Gender power relations

In the case of the *saca cena*, transgression takes on a moral character due to the unconventional gender roles assumed by female participants. The overt exercise of sexual power by women, as found in the survivor, is a precursor to the *saca cena*. The justification of the exchange of economic advantage for sex, as seen above, is one form of this power. Furthermore, the arena of struggle for moral status is centred on control over women's reputation as a good girl, properly raised, respectful of authority (men's control), and her value as a reproductive vessel.

> Of course it's the guys that *saca cena* more. A woman would never want to expose herself, to have a boyfriend only for that moment, because who's going to be ruined is the woman, not the man.[190]

For men, sexual adventurism enhances one's status. The expectation that men are sexually experienced and competent belies the reality that in many circumstances there is an overbearing weight of expectation placed on men. Women suffer the double standard that they

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[188] A similar theme was identified in Cameroon .
[189] FGD #707A / 18 years old / ♀ / 10th class / out of school / sexually active .
[190] FGD #704T / 16.5 years old / ♀ / 9th class / out of school / sexually active

ought not have sex outside the cultural boundaries of marriage while men are expected to experiment sexually (Knodel, VanLandingham, Saengtienchai et al. 1996; UNAIDS 1999b).

> Men all say [exaggerate] that they *saca cenas*. A man with many women is a '*mulherengo*' [womaniser], and a woman is a '*tourista*' [tourist] or '*puta*' [whore].[191]

Male sexuality, in the form of machismo, is based on the dominant ideology of sexual adventurism, initiation (with a prostitute) and sexual conquest. This ideology sees male sexuality as biologically driven and predatory: men need frequent sex and a variety of partners, while women are essentially passive (Heise, Moore and Toubia 1995) which often places women at disadvantageous positions vis-à-vis the negotiation of condom use and susceptibility to HIV and STI infections (Weiss, Whelan and Rao Gupta 2000).

Changes in the social expectations of the modern woman as sexually assertive has forced men to accommodate themselves to changes in gender roles (e.g., doing more housework, defending women's right to work). Nevertheless, the prevailing discourse of good/bad women, men's natural sexual assertiveness, and women's natural inclination to marriage and child-bearing persist (Mason 1994; UNAIDS 1999b; MacPhail and Campbell 2001).

> Some [girls] do [engage in *saca cenas*], yes. But they are 'bad' [girls]. I can say that others have them because I know that some girls have these things and because they have needs and they're used to doing that. So in order to not [bother their boyfriend] they go to another.
>
> Women who have *saca cenas* are badly educated [*ma acostumadas*] ... women who do this ruin themselves ... if you betray your boyfriend then you're not worth anything. A *saca cena* gives [her] no value, there's no friendship, no conversation ...[192]

If the protection of one's reputation was paramount, women would not engage in *saca cena* at all. They do because the *saca cena* is a loose category of behaviour with several overlapping meanings. As Kitzinger (1995) suggests, a slag in England has multiple meanings, so too the *saca cena* can be seen as a catchall category for someone poorly raised or educated, a freak, or *pita* [casual girlfriend] (see Chapter 7). Absent from this categorisation is the *saca cena* as a powerful woman, confident in the pursuit of her sexual and social desires now and in the future.

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[191] FGD #713A / 18 years old / ♂♀ / 10th class / out of school / sexually active
[192] FGD #704A / 16.5 years old / ♀ / 9th class / out of school / sexually active

Also notably absent from the moral discourse of the *saca cena* is the virgin cultural script. When explored in interviews and focus groups, the concept of virginity proved to be problematic. Few placed a high value on virginity, especially men who see inexperience as a liability in a future mate. Women are subjected to conflicting messages about virginity, with traditional values placing a high value on purity while pressure from peers disparaged those who remain virgins.[193] Elsewhere it has been noted the changing value placed on virginity is intrinsically linked to notions of fertility, either associated with the belief that virginity at marriage will ensure fertility (Renne 1993; 1996) or that childbirth prior to marriage is proof of a woman's ability to conceive (Gage-Brandon and Meekers 1993).

The antagonism toward men who engage in *saca cenas* in the following passage indicates the blurring of partner types, the limited options young women have in expressing their sexuality, and the desire to establish lasting relationships. Considerable antagonism toward men who engage in *saca cenas* is evident from the way that women speak about their relationships.

For early school-leavers, the *saca cena* may not provide the same neutral venue for sexual experimentation. Women justify their roles in the *saca cena*, either in participating in it or resisting it through the use of other relationship types such as the *pito* or intergenerational sex. Nevertheless, equal condemnation of women who engage in *saca cenas* was meted out.

> ... a *saca cena* is a guy [who] only wants you for that moment ... [He] never gives you time to talk about problems [or] give you any value. It can end badly ... he can beat you or do whatever it is he wants ... he won't even call you, then one day he'll be back. Ha! Just show up at your house [and] ask for forgiveness. It seems like us women at times go around looking for it ... always the same thing happens ... you end up in bed, afterwards he's gone again ... it's always like this.[194]

Where the *saca cena* devalues the moral constitution of a woman and to a lesser extent a man, alternative partner types such as a *pito* can actually increase the social standing of both.

> A *pito* is more affectionate; he's a friend with whom you can talk ...with a *pito*, most of the time, you don't have that 'crap' about taking you to bed. He does everything to please you, he only wants to take you out, show you off to his friends, hey man here's my *pita*, he never says girlfriend, they say they have a beautiful 'sugar' [*chuga bonita*], and so on.[195]

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[193] see Ogbuagu and Charles (1993); Asera, Bagarukayo, Shuey et al. (1997); Kinsman, Nyanzi and Pool (2000); Roth, Fratkin, Ngugi et al. (2001).
[194] FGD #704T / 16.5 years old / ♀ / 9th class / out of school / sexually active
[195] FGD #704T / 16.5 years old / ♀ / 9th class / out of school / sexually active

Young women assert their sexuality in a directed manner, either as a means of sexual satisfaction, to assert her control or resist domination in a relationship, or as a way of maintaining her identity.

> It's not always [the guy] who wants to [have sex]. If I want it, I'm going to make sure that he knows that I want it. The women sometimes pressure the men. When it suits them they caress and kiss, the men give in quickly.
>
> A women doesn't pressure, she seduces. When a guy is reluctant or uninterested (*tapado* – stopped up), he doesn't have any initiative, she has to insist because sometime she wants to [have sex]. A woman has to put some pressure when she feels like it. If I'm married and my husband comes home from work really tired, I'm going to insist and in the end he's going to give in. The kind of pressure that men and women use is different. A woman uses seduction and sometimes she resorts to blackmail and says 'you don't want to [make love] because you have someone else.'[196]

## 8.6 Innovation and condom use: From practice to norm

Most notable and discouraging throughout the length of the research project was the lack of consistent condom use by the young people interviewed. The sole exception was a limited group of innovators who have taken on consistent condom use as the norm, however in an unexpected manner. This group consisted predominantly of younger women, less than 20 years of age, who were still in school. That fact that better educated individuals would eventually avail themselves of the abundant information on HIV/AIDS risk and prevention methods is not surprising and is consistent with the literature (Vandemoortele and Delamonica 2000). However, educational attainment and associated aspirations do not sufficiently explain the *saca cena*. If risk mitigation was the only objective of young women, they could abstain altogether or use condoms consistently with their primary partners. Rather, young women choose to engage in risky sexual liaisons with a *saca cena* using condoms, and maintain a main boyfriend where condoms are used rarely. The contrast between the image of the daddy's little girl by day and *saca cena* by night is remarkable.

While condom use by younger women during the *saca cena* is notable, it is the context of the *saca cena* that makes the adoption of condom use so important. Firstly, the *saca cena* is inherently a risky behaviour in both epidemiological terms as well as in the local lexicon of risk. It consists of a high degree of sexual mixing in a setting marked by high rates of STIs and an expanding epidemic of HIV/AIDS. Secondly, the *saca cena* is a specific type of occasional partner associated with a reconfiguration of gender roles. The practice allows women in particular to explore their sexuality in ways not commonly accepted by Mozambican society.

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[196] FGD #707A / 18 years old / ♀ / 10th class / out of school / sexually active

The *saca cena* also gives space for women to be confident and aggressive in their sexuality without being categorised as a survivor. Despite the risks, the *saca cena* persists because it allows for a degree of independence and adventure without threatening the stability of one's principle relationship.

Why, then, are condoms accepted under these circumstances and not during other risky liaisons? On a superficial level, it would seem that partner characteristics combined with her educational attainment were principal determinants of safer sex practice. For most young people in Maputo, partnership type drives risk perceptions and condom use. For the *saca cena*, risk is not assessed on partner characteristics such as family, dress, familiarity, or wealth; instead condom use with a *saca cena* has become norm. The last *saca cena* script is a good example. In this case, the young man grabbed a condom without thinking about or asking her. The motive behind the use of condoms is less focused on the characteristics of the partner, and more on one's own individual aspirations for the future. This indicates a shift in the locus of control to the individual, as well as the projection of the consequences on the future, and suggests a fundamental shift in how risk is perceived and mediated by this cadre of individuals.

The normative effect of the school environment also appears to support more consistent condom use – especially with the *saca cena*, but not with principal partners. The principal concern for young women in stable relationships in school is to avoid pregnancy, not STIs or HIV/AIDS. Condom use in stable relationships has come to mean distrust, while condom use in a *saca cena* means playing by the rules.

## 8.7 Conclusion

The *saca cena* is an outlet for the expression of sexual desire and pleasure while functioning as a social prophylaxis by mitigating damage to young women's reputation, the break up of stable relationships, and exposure to an STI or HIV. The performance of gender roles seen in the *saca cena* reflects a de-linking of risk assessment and partner characteristics. Condom use is driven by assessment of partner characteristics – do I know her/him, do I know her/his family, what does she/he look like, and does she/he have money. The practice is counterbalanced by the survivor. A survivor is an individual with no responsibility, nor concern for the implications of his or her actions. Casual sex and the non-use of condoms are typical elements of the survivor lifestyle, which also consists of spending every night at the discos, hanging out with friends, and disrespect for authority. The *saca cena* shares the same *joie de vivre* but chooses to mitigate the risk associated with the survivor lifestyle by practicing safer

sex. Young people in Maputo are thus exploring the boundaries of gender roles by reversing some of the power dimensions therein, and as a result have contributed to a disconnect between perceived risk and partner type, leading to the incorporation of condom use as part of the *saca cena* identity. Risk assessment by superficial categories is made irrelevant because to *saca cena* is to use a condom.

The *saca cena* has become embedded in discourse and practice of sexual scripts in several ways. It challenges the dominant discourse of sex for procreation, economic security, and emotional intimacy. It promotes sex for gratification but not without consequence or risk. It still provides far more rewards for men than for women, who are at times sanctioned for participating in the practice. Young people must negotiate this contradictory landscape, while staking out their own identity of what it means to be young in Maputo today.

As a behavioural script, the *saca cena* phenomenon provides a window on the process of behaviour change in the urban, youth context. It illustrates how the sexual practice of young people reflects larger social norms but also serves to introduce modifications to these norms through the discourses of sexual expression and risk. The representation of the *saca cena* as an idealised form of sexual expression can be seen as a metaphor of behaviour change with positive and potentially negative outcomes. Among those who have adopted exclusive condom use during *saca cenas*, the practice challenges the cultural discourse of monogamous, stable sexual unions while satisfying societal demands to practice safer sex. Nevertheless, the practice threatens hierarchal structures of social and sexual control, and thus negative discourses such as unbridled female sexuality have emerged as sanction.

# 9 CONCLUSION

The aim of this thesis is to improve understanding of the sexual behaviour of young people in Africa, the normative context in which it takes place, and how this differs from the assumptions guiding behaviour change interventions. I demonstrate how behavioural change interventions attempt to influence individual sexual practice, but inadvertently perpetuate many of the biases that lead to risky sexual behaviour. Without a clear understanding of how change happens, and how meaning becomes vested in practice, interventions will inevitably fail in promoting healthy lifestyles and preventing the transmission of HIV and STIs for young people.

The four objectives set forth in the thesis have been met. First, I have described the patterns of youth sexual practice in Maputo in 2000 and the risk context in which it takes place. Second, I have identified the normative context in which risky sexual practice occurs and how the norms driving risk differ fundamentally from the assumptions guiding behaviour change interventions. In doing so, I critique the normative assumptions of a behaviour change intervention and analyse the breadth and scope of interpretation of its messages by the target audience. Third, I present the case of the survivor which demonstrates how gender and power relations define and control sexual identity and determine sexual choices made by young people. Fourth, I show how and why some young people in Maputo come to terms with risk, redefine their sexuality and, in the process, adopt innovative sexual behaviour such as condom use.

The apparent gap between knowledge and practice obscures the logic inherent in young people's risk practices. I contend that young people make this link and react in reasonable ways based on the risks they see in their lives, the perceived immediate consequences of such actions, and the resources at their disposal. However, these responses are largely mediated by the social and sexual identities young people assume. For the purpose of structuring effective interventions, policy makers need to know what these perceived risks are and what resources can be deployed to modify them.

## 9.1 Empirical contribution

This thesis fits within a wider body of work which seeks to empirically map the factors which contribute to young people's vulnerability to HIV/AIDS. The results presented illustrate how young people in Maputo mirror similar trends in sexual practices as young people elsewhere in southern Africa. At a macro level, a consistent picture of young people has emerged across the region. The average age of first sexual intercourse is early, at around 16

years old (Cleland and Ferry 1995). The length of time between first sex and marital union is increasing (Savage and Tchombe 1994). Young men tend to have more sexual partners than young women, although the age difference between partners is greater for young women than men (MacPhail, Williams and Campbell 2002). Pregnancy is the principal concern or risk perceived by young people, with STIs and HIV/AIDS following in order of importance. At the same time, having children reflects the strong positive value placed on children as proof of fertility and adulthood (Preston-Whyte and Zondi 1992). Marriage for most urbanised young people is an idealised goal which is often unattainable because of the economic marginalisation (Kaufman, de Wet and Stadler 2001). Condom use among young people is inconsistent and dependent upon partner type (Meekers and Klein 2002). Condom use with one's principal partner is acceptable only for the prevention of pregnancy, with secondary partners condom use is more common but inconsistent (Meekers and Calves 1997). Violence and coercion play an important part in sexual interactions, with women having little scope to refuse sex or demand condom use without negative consequences (Wood, Maforah and Jewkes 1998).

However, the research presented in this thesis goes beyond the empirical mapping of sexual practice; it seeks to uncover the meanings associated with sexual practice, the circumstance in which it occurs, and the structural factors which contribute to its presentation. The analysis presents the contexts in which sexual practice takes place, meanings ascribed to sexuality over time, the organisation of sexual cultures, and the resulting sexual identities which Mozambican young people have created for themselves. The study follows a growing trend to document sexual meanings, cultures and identities (Dowsett, Aggleton, Abega et al. 1998; UNAIDS 1999b; Paiva, Ayres and França Jr. 2004). Moreover, the analysis presented focused on the normative assumptions found in a behaviour change intervention seeking to change individual sexual practice. The analysis is thus rooted in a context, time, and place. Young people themselves are given the opportunity to react to these intervention scripts, reinterpret them, and reframe them in ways that makes sense to them.

### *9.1.1 The prevention discourse*

This thesis addresses the question of how the AIDS epidemic is constructed in public discourse and what young people do in their daily lives to accommodate these discourses. Discourses are the ways in which people talk, think and conceptualise something. They contain a worldview, sets of assumptions and common understandings, and non-verbal cues to action (Pool 1997). The public discourses around AIDS are many and often competing. The discourses identified in this thesis reflect social, cultural and historical forces that drive public

perceptions of the epidemic and of sexual practice. Change interventions, like research interventions, perpetuate discourses of risk, prevention, and morality. Young people in Maputo, likewise, express conflicting discourses and counter-discourses.

How national and international NGOs in Mozambique responded to the AIDS epidemic is indicative of popular conceptions of the severity of the epidemic, as well as the stigma associated with it. The discourse adopted by these entities mirrors that of the Government of Mozambique; the epidemic is largely a medical crisis which calls for a medical response. In Mozambique, the medicalisation of the epidemic contributed to the uni-dimensional response and delayed the mobilisation of society as a whole.

The coincidental shift in the medical discourse occurred at the same time as the fieldwork for this thesis. Attention to the epidemic in Maputo suddenly galvanised. The elite took notice and inter-sectoral approaches came into vogue. The *Jeito* Project reflected the predominant medical discourse through prevention activities structured around individual determinants of behaviour. As we have seen from the behaviour change models employed by the Project, behaviour change was first conceptualised as a linear pathway to change, and then as an individual-centred model based on the precursor of individual risk assessment. The *Jeito* Project demonstrates how models of behaviour change typical of such interventions contain biases that ultimately make such interventions less effective. A crucial shortcoming of individual focussed models is the failure to account for the heterogeneity of young people as sexual agents. Interventions lack a critical reflexivity of their inherent biases which in turn shapes how they interact with their constituents.

The danger of such discourses is that they are ahistorical and justify an artificial triage of action. Intervention agents choose to ignore the larger structural forces driving sexual risk-taking rather than challenge the narrow focus of intervention modalities. Beyond the remit of prevention interventions are such factors as economic development, girls' education, curriculum development, STI management and control, care and support of orphans and vulnerable children, living positively, and the roll-out of ARVs.

However, taking a structural view of the epidemic helps to place risk in context, and contributes to the understanding of how efforts to control the epidemic have had both positive and negative consequences. The underlying causes of the epidemic are often dismissed as irrelevant or outside the responsibility of organisations seeking to design and implement behaviour change interventions. Certainly poverty, poor health status, social dislocation, and

migration all contribute significantly to the epidemic. Ignoring these factors can only undermine the effectiveness of prevention and control measures. There is no good time to invest in infrastructure or to train medical personnel in STI management and anti-retroviral therapy. Likewise, investment in girls' education would seem a distant response to the epidemic, but as I have demonstrated in this thesis, young women are both at greater risk and at the vanguard of behaviour change in Maputo. Investment in creating aspiration is perhaps the single most important behaviour change strategy to date as evidenced by the literature on the effects of education on HIV/AIDS prevention (Vandemoortele and Delamonica 2000; de Walque 2002; Hargreaves and Glynn 2002).

The prevention discourse espoused by the Project reflects the patriarchal nature of externally imposed change interventions which work at the macro level to integrate the perceived needs and requirements of target groups. Even if aware of these biases, methodological and structural barriers constrain the capacity of an intervention to respond to local contexts. The discourses embedded in the two Project activities described in Chapter 6 are illustrative of how an intervention supposedly conscious of and acting against harmful gender ideologies can remain blind to the gender discourses present in its own intervention activities.

### *9.1.2 The risk discourse*

Maputo youth have been quick to assume an identity of prevention that indirectly reflects the pressure placed on them to act, but without the necessary changes in the social and economic forces driving sexual risk. When asked, the typical male youth responds that he takes precautions (*anda prevenido).* The statement represents an idealised projection of the self and not necessarily translates into prevention practice. This discourse is ambiguous at best. To take precautions can mean many things. In discussing abstinence, young people respond that indeed they practice abstinence, although their definition of abstaining does not necessarily mean celibacy. Rather, abstinence is defined as refraining from having sex outside their normal relationships. Abstinence is a form of social quarantine in which suspect individuals, based on ephemeral characteristics, are abstained from.

The ABC discourse of prevention is largely seen as irrelevant to young people in Maputo. Most considered AIDS an important issue to society but not a personal risk. Young people saw unplanned pregnancy or an STI as much more problematic. AIDS represented a danger in the distant future, but a pregnancy would be disastrous, especially for those still in school. A STI would likewise be problematic, not for the health implications per se, but for the

potential harm it could do to one's principal relationship. It could lead to the break-up of a serious long-term commitment relationship or to physical violence.

### *9.1.3 The campaign discourse*

The discourses presented in the Project activities demonstrate rigid sexual scripts that contrast with the nuanced and flexible scripts presented by young people. The radio campaign offers scenarios which failed to present a credible reality for young people, reflected dominant discourses around male hegemony and female acquiescence, and yet employed contradictory points of conflict and resolution. The binary oppositions evident from the radio plays – female/male, faithful wife/cheating husband, condom-user/non-user, and responsibility/pleasure – reinforced the predominant discourses found in Mozambican society, yet failed to challenge the role of these discourses in perpetuating exposure to risk of infection.

In the *fogo cruzado* narrative exercise, participants were given the opportunity to challenge the dominant discourses presented by the Project. In Casual Sex Negotiation women exploited gender norms to guide men toward more protective paths. The dramatisation captured the style and vibe of young people and demonstrated the variety of outcomes possible in a given interaction, which contrasts sharply with the linear conclusions presented in the *fogo cruzado*. In Space as Determinant we saw how opportunity and location were important determinants in risk for young people. Here the discourse of biological imperative and transgression of space largely determined risk behaviour. By entering a gendered space, the woman lost her basic right to say no to sexual intercourse. While contested, the weight of the male domination won out. In Confrontation over an STI, we examined how risk and violence were intermingled as a wife confronted her husband after she was diagnosed with an STI. The lack of options for her was apparent where risk and violence was inextricably linked to gender ideology. When confronted with overwhelming evidence of his infidelity; the husband resorted to violence to uphold his position of dominance. Finally, the dramatisations presented in Negotiation Style illustrated how the one-dimensional, tidy responses offered by the radio plays and *fogo cruzado* lacked the resilience to withstand the gender roles and power relationships that placed women at a decided disadvantage in negotiating condom use. Counter scripts however showed how the Negotiation Style discourse could be inverted to allow men to cede power to women.

### *9.1.4 The transgression discourse*

Gender roles provide limited scope for men and woman to express their sexuality, desires, and concern for the risks they face. The analysis presented in Chapter 7 established the

role of social learning of gender roles in sexual identity and revealed how young people come to acquire risky sexual practices. Gender roles drive risk practice, but must be regulated and maintained; lending insight into how such roles may be altered to diminish the risks therein. The survivor identity demonstrated how gender norms function as a mechanism of social control and resistance among young people in Maputo. Transgression defines boundaries of social control but can also challenge dominant gender sexual scripts. Violence and moral approbation are important elements in the control of sexual identity, and resisted through counter-normative practices. The safer sex discourses expressed by young people in Maputo are placed in a larger context of risk. Life in Maputo is precarious and risky, sexual risk is just one of the many risks a young person must cope with.

### *9.1.5 The counter discourse*

The *saca cena* illustrates how sexual practice reflects dominant cultural scripts; how some individuals adapted practice to fit change due to the threat of HIV/AIDS; and, how competing notions of risk are resolved on a practical level through sexual experimentation combined with protective practices. The representation of the *saca cena* as an idealised form of sexual expression can be seen as a positive enhancement to sexual repertoires. As a counter discourse, it is used to challenge the dominant norm of monogamous, stable sexual unions while satisfying personal demands for sexual adventurism. In the latter case, the identity is a challenge to controlling discourses of unbridled sexuality and disrespect for authority.

Through the *saca cena*, I have established how sexual innovation has occurred among young people in Maputo, and more importantly, how it insulates young people from the moral approbation that accompanies transgression from gender norms. The *saca cena* combines both the need for sexual experimentation with risk reduction practices. Contrary to the exhortations expressed by safe sex campaigns, young people continue to go to bars to *curtir* and to have casual sex, but not all put themselves at peril in doing so. While the innovation represented in the *saca cena* does not eliminate the structural impediments to behaviour change, such as economic dependence, the combined weight of innovation may well alter the social norms that drive high risk sexual behaviour. Moreover, understanding the process of innovation may well assist future interventions to influence behaviour change.

The *saca cena* is a nascent indicator of behaviour change and placed within the context of local risk discourse, sexual practice, and changing cultural scripts. The *saca cena* is not a new source of risk of HIV/AIDS for young people. The practice of one-night stands has been around long before HIV/AIDS came on the scene. As a contemporary practice, however, it has

become altered to accommodate new meanings of sexuality, gender power relations, and social interaction. The practice has contributed toward the reconfiguration of power relations between men and women. The *saca cena* challenges the dominant discourse of sex for procreation, economic security, and emotional intimacy. It is an adaptive response to the threat of HIV/AIDS which resolves competing notions of risk and the need of young people for both sexual experimentation and protective practices.

The *saca cena*/survivor complex can be summarised as the following: casual sex is a dominant form of sexual expression among young men and women in Maputo, and many who engage in such acts use condoms. However, the two use condoms for different reasons. Younger women, especially those under 20 years old and still in school, use condoms consistently with *saca cenas*. Condom use is not driven by a constructed definition of risk based on the type of relationship or the characteristics of their partner. For the survivor, it is the attributes of the person that drives condom use. The survivor as an identity and moral category demands condom use as a means of maintaining a separate space from other relationships. Without which, the survivor category would be meaningless, and no distinction could be drawn between that and other categories of relationships that bring equal risk, such as a prostitute, *pita*, or even a girlfriend.

The *saca cena* demonstrates the association between risk perception, condom use and partner type as expression of youth sexuality and concomitant gender roles, for example sexual experimentation combined with protective measures against unwanted pregnancy (reputation and early school-leaving), STIs, and more remotely HIV/AIDS. This phenomenon is part of an ongoing project of modernity whereby local practice is mediated by and contributes to changing notions of self among young men and women in Maputo.

## 9.2 Theoretical contribution: How behaviour change interventions work

The theoretical contribution made by this thesis is twofold: it describes how young people in Mozambique make their way in the world; and, it applies practice theory to the formation of sexual identities in a developing country context. Young people are active agents engaged in a process of defining their social and sexual identity, not powerless victims of social and economic factors that override individual agency. However, structural and normative factors play an important role in shaping sexual practice. This thesis examines how social norms shape individual behaviour, and in turn, how everyday practice comes to shape norms. Practice theory demonstrates how we come to do what we do, and in the process, illuminates

how meaning (morality, risk, and identity) becomes attached to practice. I apply practice theory to specific behaviour change interventions to demonstrate how meaning is ascribed to such interventions and the actions they promote. All AIDS prevention interventions implicitly or explicitly incorporate one or more model of behaviour change into their design. Likewise, most models of behaviour change focus on the individual and share a common set of features and constructs in trying to reduce risk behaviours. However, few interventions have effectively accommodated the social and cultural contexts which place certain groups at greater risk than others.

To explain how behaviour change works among young people in Maputo, I documented young people's sexual behaviour, the normative context in which sexual practice was situated, and how behaviour change interventions addressed young people. I examined the behaviour change process through a social construction framework, critiqued several of the most commonly used individual-oriented models of health behaviour, and demonstrated how and why they fail to explain youth sexual practice in Maputo.

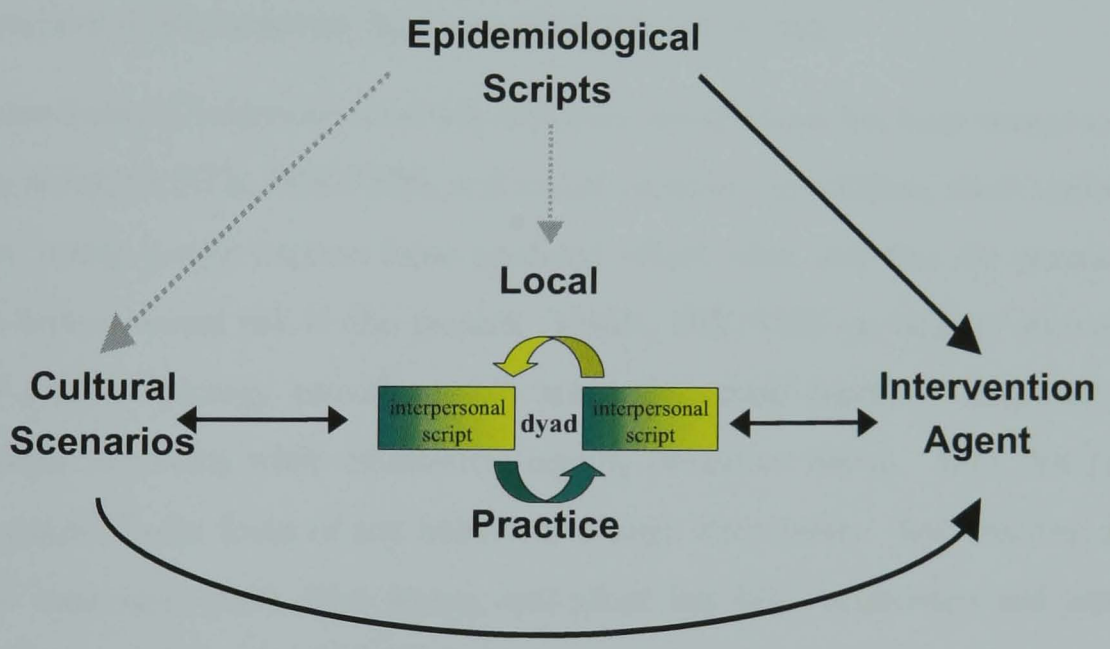
The application of script theory to examine the personal and interpersonal characteristics of sexual interaction presents a theoretical approach to behaviour change that has not been adequately studied in a developing country context. Script theory served as an unifying metaphor for how individuals in the context of a dyad come to make sense of the confusing and contradictory ritual of relationship formation and sexual practice. By examining the contexts and patterns which lead to youth sexual risk-taking, interventions may better address the needs of young people as targets of their programmes. The risk contexts identified in this research document how sexual practice creates social identity. Risk mitigation as well as risk-taking can affirm one's position within a group, and at the same time function as the boundary for exclusion from others, which ultimately comes to shape individual and group identity.

Script theory also served as a framework to demonstrate how sexual culture and the social construction of risk shape implicit assumptions about how behaviour change happens, both in terms of individual actions and that of change agents which impose external models of risk assessment. However, script theory alone was not sufficient to the task of capturing the role behaviour change interventions play promoting the adoption of safer sex practices. To this end, I added my own model of behaviour change that incorporates the prevention discourses found in behaviour change interventions, which in turn is directed at the objects of prevention – young people. When combined, the two frameworks contributed to a critical view of young people's

sexual interactions and the intervention purporting to change young people's sexual practices (see Graphic 13).

The combined framework used the metaphor of script theory to take a snapshot of a given sexual interaction, and then added the modifying effect of the behaviour change intervention messages. The narrative exercise presented in Chapter 6 was undertaken using this combined framework. The exercise illuminated a deeply complex process that required adaptation of multiple levels of meaning, power, and practice. The process of change is continually mediated by layers of interpretation between the individual actor and change agent. At the individual level, young people in Maputo continually absorb and interpret the prevention messages directed toward them. How these messages are perceived and subsequently interpreted as safer sex scripts illustrates the process of message integration and ultimately behaviour change.

***Graphic 13: Combined model of script theory and intervention agent***




Sexual scripts impact on individual action through the definition of habits, internalised behavioural patterns, routines, sanctions, and rewards. At the same time, scripts allow for individual manipulation and deviation. The sexual scripts identified were not linear or consequential, rather they presented a case of dynamic interaction derived from interpersonal interactions at the moment, and mitigated by self-narratives about what the interaction means. The addition of a third party to the dyad, in the form of the behaviour change scripts promoted by a change agent, reflects both the media channel used to convey them as well as implicit assumptions about how change should work.

The combined behaviour change model I present in Graphic 13 attempts to capture this dynamic and demonstrate how change agents reflect an ideology of biomedical determinism

while attempting to respond to the needs of their target audience. Identifying and analysing the implicit assumptions from the perspective of both change agent and participant, the change agent may effectively respond to local contexts and incorporate local risk perceptions in their activities. Most interventions fail to do so however, because of a lack of introspection of how risk is constructed locally as well as an inability to systematically incorporate the participation of its target groups. Understanding individual and group perceptions of risk associated with HIV/AIDS transmission and the subsequent actions taken to mitigate perceived risk improves the effectiveness of AIDS prevention efforts.

## 9.3 Policy and programme implications

The main policy question presented in the thesis centres on how to promote behaviour change to prevent transmitting HIV/AIDS among young people. Can interventions adequately reflect the needs of their target population without recognising their own internal biases towards individual models of behaviour change? At the same time, can interventions incorporate local beliefs and practices which determine how young people perceive risk?

Gendered sexual behaviour reflecting dominant social norms has been shown to place young people at risk for STIs, HIV/AIDS, and sexual violence. In addition, much variation is found in how young people express these gendered sexual roles, and thus the potential for innovation to reduce sexual risk is also present. Ideally, HIV/AIDS prevention interventions incorporating gender ideology provide a safe arena for young people to negotiate more favourable sexual outcomes while establishing equally protective norms. How this process might occur should be the focus of any behaviour change intervention. Interventions should focus on how innovators resist these norms, and adopt less risky behaviours and practices. Structural barriers continue to impede individual innovation, although collectively such innovation can contribute to positive changes in norms.

Interventions must also incorporate positive innovation into the discourse of behaviour change. The question persists whether they can. First, can an intervention maintain the introspection and downward accountability necessary to stay true to its target audience? Few examples of such interventions exist in the literature. The answer based on the evidence presented in this thesis is no, given the form and structure of top-down behaviour change interventions as they exist to date. Interventions by nature tend to be upwardly accountable, reflecting the discourses and biases of their donors while yielding to special interests in society hostile to the notion of young people as sexual beings. The innovation represented by the *saca*

*cena* places the counter-discourse of female sexual adventurism in direct conflict with conservative elements in Mozambican society. The *saca cena* represents everything that parents fear for their children. Antagonism toward the practice may well provide added stimuli for young people. It also subverts the ABC discourse of prevention interventions. As a form of safe transgression, the practice embodies an expression of risk-taking, independence, breaking boundaries and establishing of new ones, experimentation and instant gratification.

Young people in Maputo are making active choices about the risks they engage in. However the structural basis of these choices places some at greater risk than others. With the *saca cena*, there is evidence that some individuals managed to negotiate the treacherous path of risk perception and arrived at a practice that pushes the envelope of safer sex. Less likely is the prospect of a behaviour change intervention taking on the *saca cena* as a viable intervention outcome. Interventions possess their own cultural biases and tend to reflect more conservative elements of social change in an attempt not to threaten the viability of their programme as a whole. While the *saca cena* may reside outside the perceived remit of a change agent, the cadre of innovators who have adopted condom use represent an important resource for behaviour change interventions. It is incumbent upon change agents to recognise and harness such resources if prevention efforts are to take on broader social acceptance.

Ultimately, the answer to the behaviour change conundrum lies with these young people. By examining how gender and power relations define and control sexual identity, I demonstrated how gender ideologies mediate sexual choices for young people. In the survivor identity, I provided an analysis of the social control exerted by dominant gender ideologies, as well as the way in which transgression of gender roles carries enormous power in defining youth sexual identity. The analysis culminated with an example of how gender ideologies can be inverted to support novel, protective practices. This is the case of the *saca cena*, a practice that embodies how and why some young people in Maputo have come to terms with risk, redefining their sexuality and adopting innovative sexual practice, including condom use.

## 9.4 Epilogue

### *9.4.1 What-if: A personal note*

The use of the *Jeito* Project as a case study and vehicle for this thesis is self-critical, similar to the way in which Campbell (2003) deconstructs the intervention she worked on.[197] As a principal advocate, manager and implementer of the PSI project, the criticisms levelled in this thesis are as much criticisms of my role in the Project as it is of others. This criticism in no way undermines much of the positive work undertaken by the Project. Nor does it satisfy the what if scenario. What if we knew then what we know now? What if we looked more closely at specific risk contexts rather than target groups? What if we were more conscious of the implicit assumptions driving our interventions, and opened up the formulation of the activities to the young people who were targets of the activities? While supposition, we would most likely have had a more effective intervention at the expense of scope. The Project would not have expanded to the national level, it would not have crowded out the market for other complementary interventions to take hold, and it could have positively influenced the prevention culture when the sector was just becoming established. These 'what ifs' are some of the lessons learned from my experience in Mozambique, and the culmination of the research undertaken for this thesis.

### *9.4.2 A changed paradigm*

Much has transpired in Mozambique since the fieldwork for the data presented in this thesis were collected. The AIDS epidemic has taken hold in Maputo and the southern provinces, forcing the elite and the country as a whole to finally accept the scale of the calamity that confronts them. Improved surveillance data are available and being used by decision makers. A new national AIDS prevention and control strategy has been published which calls for not only prevention, but for treatment of opportunistic infections, home-based care, promotion of nutrition and traditional medicine, bio-security, care and support for AIDS orphans and vulnerable children (OVCs) and their caretakers, voluntary counselling and testing (VCT), prevention of mother to child transmission (PMTCT), and ARV treatment for those already infected (MoH 2004). Over 300 million dollars has been secured from the Global Fund

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[197] On paper, the project which Campbell advised was a gold standard intervention to demonstrate that community interventions were the future of HIV/AIDS prevention. When STI results did not go down after three years of intervention, critics concluded that community projects don't work. In fact, Campbell demonstrates the project was not a community project, but an old style biomedical and behaviourist intervention with the façade of community participation.

for Malaria, TB and HIV/AIDS, the World Bank, and the Bill Clinton Foundation for ARV, PMTCT, VCT, and OVC programmes.

ARV treatment seemed like a distant and unlikely possibility in 2000. Now it will soon become a reality for many Mozambicans living with HIV. What then will become of prevention? The 2004-2008 National Strategy reiterates the same prevention strategy elaborated in the past planning period of 2000-2003, which includes a comprehensive strategy of behaviour change via ABC, VCT and service delivery of adolescent sexual health services. However, the lack of effectiveness of these initiatives so far calls into question the validity of prevention alone.

The addition of care and treatment interventions alongside the prevention strategy changes the prevention landscape dramatically. When situated within a larger continuum of individual action, community care and social support, prevention is likely to improve. VCT appears to have a positive impact on prevention. Awareness of one's status encourages those already infected to receive appropriate counselling and help them cope with the disease, as well as take protective measures against infecting their partners. For those HIV-negative, especially in high-prevalence areas, knowledge of one's negative status encourages risk reduction behaviours (The Voluntary HIV-1 Counseling and Testing Efficacy Study Group 2000). However, significant impediments continue especially around the issue of stigma and confidentiality (Castle 2003; Day, Miyamura, Grant et al. 2003; Kalichman and Simbayi 2003; Maman, Mbwambo, Hogan et al. 2003).

The moral imperative to provide ARVs and expand VCT is indisputable. The question of how this will happen has yet to be determined. Of concern is the lack of reflection of what has happened to date in the prevention sector as the country pushes forward into uncharted territory of ARV treatment. If the past is any indicator of the future, the profound failure to account for the biases and ineffectiveness of condom promotion for young people bodes ill for treatment. Furthermore, little research into the uptake and use of VCT in Mozambique has been done. Likewise, there is limited understanding of the stigma and discrimination associated with revealing one's HIV status. Once attention has turned back to prevention, as it may well do, the same discourse of biomedical, behaviourist, individual-focused prevention may prevail and leave young people to fend for themselves to make their way in the world.

## 10 BIBLIOGRAPHY


Abramson, P. R. (1992). Sex, Lies, and Ethnography. The Time of AIDS: Social Analysis, Theory and Methods. G. Herdt and S. Lindenbaum. Newbury Park, CA, Sage: 101-123.

Adib, S. M., J. G. Joseph, D. G. Ostrow, M. Tal and S. A. Schwartz (1991). "Relapse in sexual behavior among homosexual men: a 2-year follow-up from the Chicago MACS/CCS." AIDS **5**: 757-760.

Agadjanian, V. (1995). "Fertility and society in Maputo, Mozambique." Ann Arbor, Michigan, UMI Dissertation Services: 9616928.

Agadjanian, V. (1998a). "Economic security, informational resources, and women's reproductive choices in urban Mozambique." Soc Biol **45**(1-2): 60-79.

Agadjanian, V. (1998b). ""Quasi-Legal" Abortion Services in a Sub-Saharan Setting: Users' Profile and Motivations." International Family Planning Perspectives **24**(3): 111-116.

Agadjanian, V. (1998c). "Women's choice between indigenous and Western contraception in urban Mozambique." Women Health **28**(2): 1-17.

Agadjanian, V. (2001a). "Negotiating Through Reproductive Change: Gendered Social Interaction and Fertility Regulation in Mozambique." Journal of Southern African studies **27**(2 (June)).

Agadjanian, V. (2001b). "Religion, social milieu, and the contraceptive revolution." Population Studies **55**(2): 135-148.

Agadjanian, V. (2002a). Informal social networks and epidemic prevention in a third world context: Cholera and HIV/AIDS compared. Advances In Medical Sociology. B. Pescosolido and J. Levy. Oxford, Elsevier Science. **Volume 8 (Social Networks and Health)**.

Agadjanian, V. (2002b). "Men's talk about 'women's matters': Gender, communication, and contraception in urban Mozambique." Gender & Society **16**(2): 194-215.

Agadjanian, V. (2005). "Gender, religious involvement, and HIV/AIDS prevention in Mozambique." Soc Sci Med **61**(7): 1529-39.

Aggleton, P. (1989). Evaluating health education about AIDS. AIDS: Social Representations and Social Practices. P. Aggleton, G. Hart and P. Davies. Basingstoke, Falmer Press.

Aggleton, P. and C. Campbell (2000). "Working with young people -- Towards an agenda for sexual health." Sexual and Relationship Therapy **15**(3): 283-296.

Aggleton, P. and I. Warwick (1997). Young People, Sexuality, and HIV and AIDS Education. AIDS and adolescents. L. Sherr. Amsterdam, Harwood Academic Publishers.

Agha, S., A. Karlyn and D. Meekers (1999). The Promotion of Safer Sex Among High Risk Individuals in Mozambique. Washington, DC, Population Services International**:** 27.

Agha, S., A. Karlyn and D. Meekers (2001). "The promotion of condom use in non-regular partnerships in urban Mozambique." Health Policy and Planning **16**(2): 27.

Ahlburg, D. A., E. R. Jensen and A. E. Perez (1997). "Determinants of extramarital sex in the Philippines." Health Transit Rev **7**: 467-479.

AIM (2003). AIM Reports No.263. Mozambique News Agency. Maputo.

Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. Action-control: From cognition to behavior. J. Kuhl and J. Beckmann. Heidelberg, Germany, Springer**:** 11-39.

Ajzen, I. (1988). Attitudes, personality, and behavior. Buckingham, United Kingdom, Open University Press.

Ajzen, I. (1991). "The theory of planned behavior. Special Issue: Theories of cognitive self-regulation." Organizational Behavior & Human Decision Processes **50**(2): 179-211.

Ajzen, I. and M. Fishbein (1980). Understanding attitudes and predicting social behavior. Englewood Cliffs, NJ, Prentice-Hall.

Alderson, P. (1998). "Theories in health care and research: The importance of theories in health care." Bmj **317**(7164): 1007-1010.

Alderson, P. and C. Goodey (1998). "Theories in health care and research: Theories of consent." Bmj **317**(7168): 1313-1315.

Allen, T. and S. Heald (2004). "HIV/AIDS policy in Africa: what has worked in Uganda and what has failed in Botswana?" Journal of International Development **16**(8): 1141-1154.

Amaro, H. (1995). "Love, sex, and power. Considering women's realities in HIV prevention." Am Psychol **50**(6): 437-47.

Anarfi, J. K. and P. Antwi (1995). "Street youth in Accra city: sexual networking in a high-risk environment and its implications for the spread of HIV AIDS." Health transition review **5**: 131-152.

Andersson, N., A. Ho-Foster, J. Matthis, N. Marokoane, V. Mashiane, S. Mhatre, S. Mitchell. T. Mokoena, L. Monasta, N. Ngxowa, M. P. Salcedo and H. Sonnekus (2004). "National cross sectional study of views on sexual violence and risk of HIV infection and AIDS among South African school pupils." Bmj **329**(7472): 952.

Arnett, J. J. (1999). "Adolescent storm and stress, reconsidered." Am Psychol **54**(5): 317-26.

Arnold, F. and A. K. Blanc (1990). Fertility Levels and Trends: Demographic and Health Surveys Comparative Studies no. 2. Columbia, Maryland, USA, Institute for Resource Development/Macro Systems.

Aronson, J. (1994). "A Pragmatic View of Thematic Analysis." The Qualitative Report **2**(1).

Asamoah, A.-A., S. Weir, M. Pappoe, N. Kanlisi, A. Neequaye and P. Lamptey (1994). "Evaluation of a targeted AIDS prevention intervention to increase condom use among prostitutes in Ghana." AIDS **8**(2): 239-46.

Asera, R., H. Bagarukayo, D. Shuey and T. Barton (1997). "An epidemic of apprehension: questions about HIV/AIDS to an east African newspaper health advice column." AIDS Care **9**(1): 5-12.

Asthana, S. and R. Oostvogels (2001). "The social construction of male 'homosexuality' in India: implications for HIV transmission and prevention." Soc Sci Med **52**(5): 707-21.

Atwood, J. D. and S. Dershowitz (1992). "Constructing a sex and marital therapy frame: ways to help couples deconstruct sexual problems." J-Sex-Marital-Ther **18**(3): 196-218.

Auerbach, J. D., C. Wypijewska and K. H. Brodie (1994). AIDS and behavior: and integrated approach. Washington, D.C., National Academy Press.

Ayman-Nolley, S. and L. L. Taira (2000). Obsession with the Dark Side of Adolescence: A Decade of Psychological Studies. Journal of Youth Studies, Carfax Publishing Company. **3:** 35.

Badiani, R., I. Zilhão, C. Bilale and P. Bailey (2000). Estudo CAP nas escolas: Conhecimento, atitudes, práticas e comportamento em saúde sexual e reprodutiva em uma era de SIDA. Relatório de Maputo. [KAP study in schools: Knowledge, attitudes, practices

and behaviours of reproductive and sexual health in the time of AIDS. Maputo Report]. Maputo, MZ, DNAJ. Direcção Nacional dos Assuntos da Juventude [National Directorate for Youth Affairs]: 56.

Bagnol, B. (1996). Diagnostico da Orientação Sexual em Maputo e Nampula. Maputo, Embaixada do Reino dos Paises Baixos.

Bagnol, B. (1998). Pesquisa Qualitativa sobre DTS/SIDA em Quelimane, Maganja da Costa e Pebane. Quelimane, MZ, Action Aid Mozambique: 101.

Bailey, R. C., R. Muga, R. Poulussen and H. Abicht (2002). "The acceptability of male circumcision to reduce HIV infections in Nyanza province, Kenya." AIDS Care **14**(1): 27-40.

Bakaroudis, M. (2003). Young People, Sexual and Reproductive Health, and HIV/AIDS. London, Univ. London, Institute of Education.

Baker, C., J. Wuest and P. Stern (1992). "Method Slurring: The Grounded Theory/Phenomenology Example." Journal of Advanced Nursing **17**: 1355-1360.

Balmer, D. H. (1994). The phenomenon of adolescence - an ethnographic inquiry. Nairobi Kenya, NARESA - Department of Psychology, University of Nairobi.

Balmer, D. H., E. Gikundi, M. C. Billingsley, F. G. Kihuho, M. Kimani, J. Wang'ondu and H. Njoroge (1997). "Adolescent knowledge, values, and coping strategies: implications for health in sub-Saharan Africa." Journal of Adolescent Health **21**(1): 33-8.

Balmer, D. H., E. Gikundi, M. Kanyotu and R. Waithaka (1995). "The negotiating strategies determining coitus in stable heterosexual relationships." Health transition review **5**(1): 85-95.

Bandura, A. (1977a). "Self-efficacy: Toward a unifying theory of behavioral change." Psychology Review **84**: 191-215.

Bandura, A. (1977b). Social Learning Theory. Englewood Cliffs, NJ, Prentice-Hall.

Bandura, A. (1986). Social foundations of thought and action. A social cognitive theory. Englewood Cliffs, NJ, Prentice-Hall.

Bandura, A. (1989). Self regulation of motivation and action thorugh internal standards and goal systems. Goal concepts in personality and social psychology. L. A. Pervin. Hillsdale, NJ, Lawrence Erlbaum: 19-85.

Bandura, A. (1994). Social cognitive theory and exercise of control over HIV infection. Preventing AIDS: Theories and methods of behavioral interventions AIDS prevention and mental health. J. L. P. Ralph J. DiClemente, Plenum Press, New York, NY, US: 25-59.

Barker, G. (2000). What About Boys? A literature review on health and development of adolescent boys. Geneva, World Health Organization: 58.

Barnett, T. and P. M. Blaikie (1991). AIDS in Africa: its present and future impact. London, Belhaven Press.

Barradas, R., J. Donato and H. Madore (2002). Knowledge, attitudes, perceptions and behaviours among employees of small and medium enterprises in Mozambique. IAS Barcelona, Barcelona, Spain.

Barreto, A., A. Mac Arthur, F. Saúte, I. Nhatave, M. Cossa, P. Duce, M. Monjane, V. Muchanga, G. Fazenda, C. Arnaldo, A. Mahomed, M. Alfeu, H. Tojais and K. Foreit (2004). Impacto Demográfico do HIV/SIDA em Moçambique [Demographic Impact of HIV/AIDS in Mozambique]. Maputo, MZ, Instituto Nacional de Estatística (INE).

Barreto, A. T. L., K. G. Foreit, P. A. Noya, I. Nhatave and M. C. Gaspar (2002). Cultural and demographic determinants of HIV prevalence in Mozambique. Paper presented at the 14th International AIDS Conference, Barcelona, Spain.

Barreto, J., J. Liljestrand, C. Palha de Sousa, S. Bergstrom, B. Bottiger, G. Biberfeld and F. De la Cruz (1993). "HIV-1 and HIV-2 antibodies in pregnant women in the City of Maputo, Mozambique. A comparative study between 1982/1983 and 1990." Scandinavian Journal of Infectious Diseases **25**(6): 685-8.

Basen-Engquist, K. and G. S. Parcel (1992). "Attitudes, norms, and self-efficacy: a model of adolescents' HIV-related sexual risk behavior." Health-Educ-Q **19**(2): 263-77.

Bastard, B. and L. Cardia-Voneche (1997). From Rational Individual to Actor Ensnared in a Web of Affective and Sexual Relationships. Sexual Interactions and HIV Risk: New Conceptual Perspectives in European Research. L. van Campenhoudt, M. Cohen, G. Guizzardi and D. Hausser. London, Taylor & Francis: 127-134.

Bastard, B., L. Cardia-Voneche, D. Peto and L. van Campenhoudt (1997). Relationships between Sexual Partners and Ways of Adpating to the Risk of AIDS: Landmarks for a Relationship-oriented Conceptual Framework. Sexual Interactions and HIV Risk: New

Conceptual Perspectives in European Research. L. van Campenhoudt, M. Cohen, G. Guizzardi and D. Hausser. London, Taylor & Francis: 44-58.

Bates, M. S., L. Rankin-Hill, M. Sanchez-Ayendez and R. Mendez-Bryan (1995). "A cross-cultural comparison of adaptation to chronic pain among Anglo-Americans and native Puerto Ricans." Medical Anthropology Quarterly **16**(2): 141-73.

Baumeister, R. F. (1988). "Gender Differences in Masochistic Scripts." Journal of Sex Research **25**(4): 478-499.

Beck, U. (1992). Risk society: Towards a new modernity. Beverly Hills, CA, Sage.

Becker, M. H. (1974). "The health belief model and personal health behavior." Health Education Monographs **2**: 324-508.

Becker, M. I. L. and J. G. Joseph (1988). "AIDS and behavioral change to reduce risk: A review." American Journal of Public Health **78**: 394-410.

Bernard, H. R. (1995). Research Methods in Anthropology: Qualitative and Quantitative Approaches. Walnut Creek, CA, Altamira Press (Sage).

Bernard, H. R. (1998). Handbook of Methods in Cultural Anthrpology. Walnut Creek, CA, Altamira Press.

Blanc, A. K. and A. A. Way (1998). "Sexual behavior and contraceptive knowledge and use among adolescents in developing countries." Stud Fam Plann **29**(2): 106-16.

Blanc, A. K., B. Wolff, A. J. Gage, A. C. Ezeh, S. Neema and S.-J. Ssekamatte (1996). Negotiating reproductive outcomes in Uganda, Calverton Maryland Macro International Demographic and Health Surveys [DHS] 1996 Dec. xxiii 215 p.

Boer, D., G. Kok, H. Hospers and F. Gerards (1991). "Health education strategies for the attributional retraining and self-efficacy improvement." Health Education Research **6**(2): 239-48.

Bohmer, L. and E. Kirumira (2000). "Socio-economic context and the sexual behaviour of Ugandan out of school youth." Culture, Health & Sexuality **2**(3): 269-285.

Bolton, R. (1989). Introduction: The AIDS pandemic, a global emergency. The AIDS pandemic: a global emergency. R. Bolton. New York, Gordon and Breach: 1-12.

Bolton, R. (1992). Mapping Terra Incognita: Sex Research for AIDS Prevention -- An Urgent Agenda for the 90s. The Time of AIDS: Social Analysis, Theory and Methods. G. Herdt and S. Lindenbaum. Newbury Park, CA, Sage: 124-158.

Bongaarts, J. (1991). "The KAP-gap and the unmet need for contraception." Population and Development Review **17**(2): 293-313.

Bongaarts, J. and B. Cohen (1998). "Introduction and Overview." Studies in Family Planning **29**(2): 99-105.

Bourdieu, P. (1977). Outline of a Theory of Practice [translated by Richard Nice]. Cambridge, Cambridge University Press.

Bourdieu, P. (1990). The Logic of Practice. Stanford, Stanford University Press.

Bowen, N. R. (2000). Traders and livelihood strategies in post-conflict Zambezia Province, Mozambique, University of London.

Bowes, J. E. (1997). Communication and Community Development for Health Information: Constructs and Models for Evaluation. Seattle, National Network of Libraries of Medicine, Pacific NorthWest Region.

Boyatzis, R. E. (1998). Transforming qualitative information: thematic analysis and code development. Thousand Oaks, CA, Sage Publications.

Boyer, C. B. and S. M. Kegeles (1991). "AIDS risk and prevention among adolescents." Social Science & Medicine **33**: 11-23.

Brafford, L. J. and K. H. Beck (1991). "Development and validation of a condom self-efficacy scale for college students." J-Am-Coll-Health **39**(5): 219-25.

Braun, V. and C. Kitzinger (2000). "The perfectible vagina: size matters." Culture, Health & Society **3**(3): 263-7.

Broadhead, R. S., D. D. Heckathorn, D. L. Weakliem, D. L. Anthony, H. Madray, R. J. Mills and J. Hughes (1998). "Harnessing peer networks as an instrument for AIDS prevention: results from a peer-driven intervention." Public Health Rep **1**: 42-57.

Brockerhoff, M. and A. Biddlecom (1999). "Migration, sexual behavior and the risk of HIV in Kenya." International migration review **33**(4): 833-856.

Brown, J. and et al (1993). "Dry and tight: sexual practices and potential aids risk in Zaire." Social Science and Medicine **37**(8): 989-994.

Bujra, J. M. (2000). Risk and trust: Unsafe sex, gender and AIDS in Tanzania. Risk revisited. P. Caplan. London, Pluto Press: 59-84.

Bukali de Graça, F. L. (2002). HIV/AIDS Prevention And Care In Mozambique, A Socio-Cultural Approach. Maputo, UNESCO/SANA - Social Development Consultants.

Bunton, R., S. Baldwin, D. Flynn and S. Whitelaw (2000). "The 'stages of change' model in health promotion: Science and ideology." Critical Public Health **10**(1): 55-70.

Burnham, R. C. (1991). "The concept of core and its relevance to the epidemiology and control of sexually transmitted diseases." Sex Transm Dis **18**: 67-68.

Buse, K. and G. Walt (1997). "An unruly melange? Coordinating external resources to the health sector: a review." Soc Sci Med **45**(3): 449-63.

Byers, E. S. (1995). "How well does the traditional sexual script explain sexual coercion? Review of a program of research." Journal of Psychology & Human Sexuality **8**(1-2): 7-25.

Caelli, K., L. Ray and J. Mill (2003). "'Clear as mud': Toward greater clarity in generic qualitative research." International Journal of Qualitative Methods **2**(2 (Article 1)).

Caldwell, J., P. Caldwell and P. Quiggin (1989). "The social context of AIDS in sub-Saharan Africa." Population and Development Review **15**(2): 185-234.

Caldwell, J. C. (1993). "How do we secure adequate data on sexual networks and the probability of HIV transmission?" Health transition review **3**(2): 205-8.

Caldwell, J. C., I. O. Orubuloye and P. Caldwell (1999). Obstacles to behavioural change to lessen the risk of HIV infection in the African AIDS epidemic: Nigerian research. Reistances to Behavioural Change to Reduce HIV/AIDS Infection. J. C. Caldwell. Canberra, Health Transition Centre: 113-124.

Calvès, A., G. Cornwell and P. Enyegue (1996). Adolescent sexual activity in Sub-Saharan Africa: do men have the same strategies and motivations as women? University Park, Pennsylvania, Pennsylvania State University, Population Research Institute: 34.

Campbell, C. A. (2003). Letting them die: why HIV/AIDS intervention programmes fail. Wetton, SA, Double Storey Books.

Carael, M., T. Mertens and J. Cleland (1993). "Data collection strategies in the study of behaviours: limited use of simple solutions to a complex problem." Health transition review **3**(2): 211-4.

Carpenter, L. M. (1998). "From girls into women: Scripts for sexuality and romance in Seventeen magazine, 1974-1994." Journal of Sex Research **35**(2): 158-168.

Carrier, J. and R. Bolton (1991). "Anthropological perspectives on sexuality and HIV prevention." Annual Review of Sex Research **2**: 49-75.

Carter, W. B. (1990). Health Behavior as a Rational Process: Theory of Reasoned Action and Mulitattribute Utility Theory. Health Behavior and Health Education: Theory, Research and Practice. K. Glanz, F. M. Lewis and B. Rimmer. San Francisco, Jossey-Bass Publishers**:** 63-91.

Castel-Branco, C. N. (2002). Economic Linkages Between South Africa and Mozambique. Pretoria, SA, Department for International Development of the British Government.

Castellsague, X., C. Menendez, M. P. Loscertales, J. R. Kornegay, F. dos Santos, F. X. Gomez-Olive, B. Lloveras, N. Abarca, N. Vaz, A. Barreto, F. X. Bosch and P. Alonso (2001). "Human papillomavirus genotypes in rural Mozambique." Lancet **358**(9291): 1429-1430.

Casterline, J. and S. Sinding (2000). Unmet need for family planning in developing countries and implications for population policy. New York, New York, Population Council**:** 44.

Castle, S. (2003). "Doubting the existence of AIDS: a barrier to voluntary HIV testing and counselling in urban Mali." Health Policy Plan **18**(2): 146-55.

Catania, J., J. Kegeles and T. Coates (1990). "Psychosocial predictors of people who fail to return for their HIV test results." AIDS **4**(3): 261-2.

Catania, J. A., D. D. Chitwood, T. J. Coates and D. R. Gibson (1990). "Methodological problems in AIDS behavioural research: Influences on measurement error in participation bias in studies of sexual behaviour." Psychological Bulletin **108**(3): 339-62.

Catania, J. A., M. M. Dolcini, T. J. Coates, S. M. Kegeles, R. M. Greenblatt, S. Puckett, M. Corman and J. Miller (1989). "Predictors of condom use and multiple partnered sex among sexually-active adolescent women: implications for AIDS-related health interventions." Journal of Sex Research **26**(4): 514-24.

Catania, J. A., L. J. McDermott and L. M. Pollack (1986). "Questionnaire Response Bias and Face-to-Face Interview Sample Bias in Sexuality Research." Journal of Sex Research **22**(1): 52-72.

CDC and The AIDS Community Demonstration Projects Research Group (1999). "Community-Level HIV Intervention in 5 Cities: Final Outcome Data From the CDC AIDS Community Demonstration Projects." American Journal of Public Health **89 (March)**(3): 336-345.

Chalmers, B. (1996). "Western and African Conceptualizations of health." Psychology and Health **12**: 1-12.

Chao, A., M. Bulterys, F. Musanganire, P. Habimana, P. Nawrocki, E. Taylor, A. Dushimimana and A. Saah (1994). "Risk factors associated with prevalent HIV 1 infection among pregnant women in Rwanda." International Journal Of Epidemiology **23**(2): 371-380.

Chapman, R. R. (2003). "Endangering safe motherhood in Mozambique: prenatal care as pregnancy risk." Soc Sci Med **57**(2): 355-74.

Chapman, R. R. (2004). "A nova vida: the commoditization of reproduction in Central Mozambique." Med Anthropol **23**(3): 229-61.

Chilvers, R., G. Harrison, A. Sipos and M. Barley (2002). "Evidence into practice: Application of psychological models of change in evidence-based implementation." Br J Psychiatry **181**(2): 99-101.

Clark, S. (2004). "Early marriage and HIV risks in sub-Saharan Africa." Stud Fam Plann **35**(3): 149-60.

Cleland, J. and B. Ferry, Eds. (1995). Sexual Behavior and AIDS in the Developing World. Social Aspects of AIDS. London, Taylor & Francis.

Cliff, J., G. Walt and I. Nhatave (2004). "What's in a name? Policy transfer in Mozambique: DOTS for tuberculosis and syndromic management for sexually transmitted infections." J Public Health Policy **25**(1): 38-55.

Cliff, J. L. (1998). "Reconstructing Health in Post-War Mozambique." ACAS Bulletin **50/51**: 3-5.

Connell, R. W. (1994). Masculinities. Berkeley, Univ. California Press.

Connell, R. W. (1996). "Teaching the boys: New research on masculiniteis and gender strategies for schools." Teachers College Record **98**(2): 206-235.

Copas, A. J., K. Wellings, B. Erens, C. H. Mercer, S. McManus, K. A. Fenton, C. Korovessis, W. Macdowall, K. Nanchahal and A. M. Johnson (2002). "The accuracy of reported sensitive sexual behaviour in Britain: exploring the extent of change 1990-2000." Sex Transm Infect **78**(1): 26-30.

Cossa, H. A., S. Gloyd, R. G. Vaz, E. Folgosa, E. Simbine, M. Diniz and J. K. Kreiss (1994). "Syphilis and HIV infection among displaced pregnant women in rural Mozambique." International Journal of Std and Aids **5**(2): 117-23.

Crawford, J., S. Lawless and S. Kippax (1997). Positive Women and heterosexuality: Problems of Disclosure of Serostatus to Sexual Partners. AIDS: activism and alliances. P. Aggleton, P. M. Davies and G. Hart. London; Washington, DC, Taylor & Francis**:** 1-14.

Crush, J., C. Mather, F. Mathebula, D. Lincoln, C. Mararike and T. Ulicke (2000). Borderline Farming: Foreign Migrants in South African Commercial Agriculture. Migration Policy Series, South African Migration Project**:** 77.

Dare, O. O. and J. G. Cleland (1994). "Reliability and validity of survey data on sexual behaviour." Health transition review **4**: 93-110.

Davis, C. (1997). Communication and Marketing for AIDS Prevention. Maputo, MZ, Population Services International.

Day, J. H., K. Miyamura, A. D. Grant, A. Leeuw, J. Munsamy, R. Baggaley and G. J. Churchyard (2003). "Attitudes to HIV voluntary counselling and testing among mineworkers in South Africa: will availability of antiretroviral therapy encourage testing?" AIDS Care **15**(5): 665-72.

Day, S. (1994). What counts as rape? Physical assault and broken contracts: contrasting views of rape among London sex workers. Sexual Violence - Issues in Representation and Experience. P. Harvey and P. Gow. London, Routledge**:** 172-189.

De Hulsters, B., A. Barreto, R. Bastos, A. Noya, E. Folgosa and L. Fransen (2003). "Geographical focusing: an intervention to address increased risk for sexually transmitted diseases during repatriation and resettlement in post-war Mozambique." Sex Transm Infect **79**(1): 77.

de Vletter, F. (1998). Sons of Mozambique: Mozambican miners and post-Apartheid South Africa. Cape Town, South Africa, South African Migration Project (SAMP): 42.

de Vries, H., M. Dijkstra and P. Kuhlman (1988). "Self-efficacy: The third factor besides attitude and subjective norm as a predictor of behavioral intentions." Health Education Research **3**(3): 273-82.

de Walque, D. (2002). How Does the Impact of an HIV/AIDS Information Campaign Vary with Educational Attainment? Evidence from Rural Uganda. Chicago, IL, University of Chicago. **November**.

de Wit, J. B., E. M. de Vroome, T. G. Sandfort and G. J. van Griensven (1997). "Homosexual encounters in different venues." Int J STD AIDS **8**(2): 130-4.

de Zalduondo, B. O. (1991). "Prostitution Viewed Cross-Culturally - Toward Recontextualizing Sex Work in AIDS Intervention Research." Journal of Sex Research **28**(2): 223-248.

Denzin, N. K. and Y. S. Lincoln (1994). Handbook of qualitative research. London, Sage.

Deven, F. and P. Meredith (1997). The Relevance of a Macrosociological Perspective on Sexuality for an Understanding of the Risks of HIV Infection. Sexual Interactions and HIV Risk: New Conceptual Perspectives in European Research. L. van Campenhoudt, M. Cohen, G. Guizzardi and D. Hausser. London, Taylor & Francis: 142-158.

Dgedge, M., A. Novoa, G. Macassa, J. Sacarlal, J. Black, C. Michaud and J. Cliff (2001). "The burden of disease in Maputo City, Mozambique: registered and autopsied deaths in 1994." Bull World Health Organ **79**(6): 546-52.

DHS (1997a). Demographic and Health Survey (DHS): Full Report. Maputo, National Institute of Statistics (INE), Ministry of Health (MISAU), Macro International-USAID.

DHS (1997b). Demographic and Health Survey (DHS): Preliminary Report. Maputo, National Institute of Statistics (INE), Ministry of Health (MISAU), Macro International-USAID.

DHS (1997c). Mozambique Demographic and Health survey [Inquérito Demográfico e de Saúde], Macro International Inc / Instituto Nacional de Estatística.

Díaz, R. M. and G. Ayala (1999). "Love, passion and rebellion: ideologies of HIV risk among Latino gay men in the USA." Culture, Health & Sexuality **1**(3): 277-293.

DiClemente, R. J. (2001). "Development of programmes for enhancing sexual health." Lancet **358**(9296): 1828-9.

Diekman, A. B., M. McDonald and W. L. Gardner (2000). "Love means never having to be careful: The relationship between reading romance novels and safe sex behavior." Psychology of Women quarterly **24**: 179-188.

Dilger, H. (2003). "Sexuality, AIDS, and the lures of modernity: reflexivity and morality among young people in rural Tanzania." Med Anthropol **22**(1): 23-52.

Dilley, J. W., W. J. Woods and W. McFarland (1997). "Are Advances in Treatment Changing Views about High-Risk Sex?" N Engl J Med **337**(7): 501-502.

Dixon-Mueller, R. (1991). The culture of silence: Reproductive tract infections among women in the Third World. New York, International Women's Health Coalition.

Dixon-Mueller, R. (1993). "The sexuality connection in reproductive health." Studies in Family Planning **24**(5): 269-282.

Dixon-Mueller, R. and A. Germain (1992). "Stalking the elusive "unmet need" for family planning." Stud Fam Plann **23**(5): 330-5.

Douglas, M. and A. Wildavsky (1980). Risk and culture. An essay on the selection of technical and environmental dangers. cc, pp.

Douglas, T. (1976). Groupwork Practice. London, Tavistock Publications.

Dowsett, G. W. (1996). Practicing Desire: Homosexual Sex in the Era of AIDS. Stanford, CA, Stanford University Press.

Dowsett, G. W. (2004). "Some Considerations on Sexuality and Gender in the Context of AIDS." Reproductive Health Matters **11**(22): 21-29.

Dowsett, G. W., P. Aggleton, S.-C. Abega, C. Jenkins, T. M. Marshall, A. Runganga, J. Schifter, M. L. Tan and C. M. Tarr (1998). "Changing gender relations among young people: the global challenge for HIV/AIDS prevention." Critical Public Health **8**(4): 291-310.

Dunkle, K. L., R. K. Jewkes, H. C. Brown, G. E. Gray, J. A. McIntryre and S. D. Harlow (2004). "Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa." Lancet **363**(9419): 1415-21.

Ecker, N. (1994). "Culture and sexual scripts out of Africa. A North American trainer's view of taboos, tradition, trouble and truth." Siecus Report **22**(2): 16-21.

Edgar, T. and M. A. Fitzpatrick (1993). "Expectations for sexual interaction: a cognitive test of the sequencing of sexual communication behaviors." Health Communication **5**(4): 239-261.

Eisen, M., G. L. Zellman and A. L. McAlister (1990). "Evaluating the impact of a theory-baseed sexuality and contraceptive education program." Family Planning Perspectives **22**: 261-71.

Epprecht, M. (1998). "The 'Unsaying' of Indigenous Homosexualities in Zimbabwe: Mapping a Blindspot in an African Masculinity." Journal of Southern African studies **24**(4): 631-651.

Epstein, H. (2002). "The Hidden Cause of AIDS." New York Review of Books **49**(8).

Evans-Pritchard, E. (1976 [1937]). Witchcraft, oracles, and magic among the Azande. Oxford, Clarendon Press.

Eyre, S., E. Davis and B. Peacock (2001). "Moral argumentation in adolescents' commentaries about sex." Culture, Health & Sexuality **3**(1): 1-17.

Farmer, P. (1992). AIDS and accusation: Haiti and the geography of blame. Berkeley, University of California Press.

Farmer, P., M. Connors and J. Simmons, Eds. (1996). Women, Poverty and AIDS. Monroe, ME, Common Courage Press.

FDC (2001). Projecto "Kulhuvuka – Corridor de Esperança [Project Kulhuvuka - Corridor of Hope]. Maputo, MZ, Fundação para o Desenvolvimento da Comunidade.

Feeney, J. A., P. Noller and J. Patty (1993). "Adolescents' interactions with the opposite sex: Influence of attachment style and gender." Journal of Adolescence **16**(2): 169- 186.

Ferrand, A. and T. A. B. Snijders (1997). Social Networks and Normative Tensions. Sexual Interactions and HIV Risk: New Conceptual Perspectives in European Research. L. van Campenhoudt, M. Cohen, G. Guizzardi and D. Hausser. London, Taylor & Francis: 6-21.

Ferry, B., J.-C. Deheneffe, M. Mamdani and R. Ingham (1995). Characteristics of Surveys and Data Quality. Sexual Behavior and AIDS in the Developing World. J. Cleland and B. Ferry. London, Taylor & Francis: 10-42.

FHI AIDSCAP (1996). How to create an effective peer education project. Guidelines for AIDS prevention projects. Arlington Virginia, Family Health International - AIDSCAP: 33.

Fichtner, R. R., R. J. Wolitski, W. D. Johnson, C. B. Rabins and M. Fishbein (1996). "Influence of perceived and assessed risk on STD clinic clients' acceptance of HIV testing, return for test results, and HIV serostatus." Psychology, Health and Medicine **1**: 83–98.

Field, M. L., J. Price, C. Niang, J. N'Tcha, I. T. Zwane, M. Lurie, M. Nxumalo, A. Dialmy, L. Manhart, A. Gebre, T. Saidel and G. Dallabetta (1998). "Targeted intervention research studies on sexually transmitted diseases (STD): methodology, selected findings and implications for STD service delivery and communications." AIDS **12**(Suppl 2): S119-26.

First, R. (1983). Black Gold: The Mozambican Miner, Proletarian and Peasant. New York, St Martin's Press.

Fishbein, M., A. Bandura, H. C. Triandis, F. H. Kanfer, M. H. Becker and S. E. Middlestadt (1991). Factors influencing behavior and behavior change. Washington, D.C., National Institute of Mental Health (NIMH).

Fishbein, M., S. E. Middlestadt and P. J. Hitchcock (1994). Using information to change sexually transmitted disease-related behaviors: An analysis based on the theory of reasoned action. Preventing AIDS: Theories and methods of behavioral interventions AIDS prevention and mental health. J. L. P. Ralph J. DiClemente, Plenum Press, New York, NY, US: 61-78.

Fisher, J. D., S. J. Misovich and W. A. Fisher (1992). Impact of perceived social norms on adolescents' AIDS-risk behavior and prevention. Adolescents and AIDS: A Generation in Jeopardy. R. J. DiClemente. Newbury Park, CA, Sage.

Fisher, W. A. and J. D. Fisher (1998). "Understanding and Promoting Sexual and Reproductive Health Behavior: Theory and Method." Annual Review of Sex Research **9**: 39-76.

Flowers, P., C. Marriott and G. Hart (2000). "'The bars, the bogs, and the bushes': the impact of locale on sexual cultures." Culture, Health & Sexuality **2**: 69- 86.

Folgosa, E., N. B. Osman, C. Gonzalez, I. Hagerstrand, S. Bergstrom and A. Ljungh (1996). "Syphilis seroprevalence among pregnant women and its role as a risk factor for stillbirth in Maputo, Mozambique." Genitourin-Med **72**(5): 339-42.

Ford, N. J. and S. Kittisuksathit (1994). "Destinations unknown: The gender construction and changing nature of the sexual expressions of Thai youth." AIDS Care **6**(5): 517-531.

Foreit, K. G. (1999). Some considerations for developing a strategic approach to the HIV / AIDS epidemic in Mozambique. Draft. Washington, D.C., Futures Group International, POLICY Project.

Foster, G. M. and B. G. Anderson (1978). Medical Anthropology. New York, John Wiley and Sons.

Foucault, M. (1979). The History Of Sexuality. Vol 1: An Introduction. London, Allen Lane.

Foucault, M. (1981). The history of sexuality. Harmondsworth, Penguin.

Frey, K. and M. Hojjat (1998). "Are love styles related to sexual styles?" Journal of Sex Research **35**(3): 265-271.

Frutchey, C. (1989). The role of community based organizations in AIDS and STD prevention. Promoting Safer Sex. M. Paalman. Amsterdam, Swets and Zeitlinger**:** 81-92.

Fuglesang, M. (1997). "Lessons for life--past and present modes of sexuality education in Tanzanian society." Soc Sci Med **44**(8): 1245-54.

Futures Group (2001). HIV/AIDS in Southern Africa: Background, Projections, Impacts, and Interventions. Washington, DC, The Policy Project, prepared for Bureau for Africa, Office of Sustainable Development, US Agency for International Development.

Gage-Brandon, A. and D. Meekers (1993). "Sex, Contraception, and Child bearing Before Marriage in Sub-Saharan Africa." International Family Planning Perspectives **19**(1): 14-18.

Gage, A. J. (1998). "Sexual activity and contraceptive use: the components of the decisionmaking process." Stud Fam Plann **29**(2): 154-166.

Gagnon, J. H. (1988). "Sex research and sexual conduct in the era of AIDS." J-Acquir-Immune-Defic-Syndr **1**(6): 593-601.

Gagnon, J. H. (1990). "The explicit and implicit use of the scripting perspective in sex research." Annual Review of Sex Research **1**: 1-43.

Gagnon, J. H., R. C. Rosen and S. R. Leiblum (1982). "Cognitive and social aspects of sexual dysfunction: sexual scripts in sex therapy." J-Sex-Marital-Ther **8**(1): 44-56.

Gagnon, J. H. and W. Simon (1973). Sexual Conduct: The Social Sources of Human Sexuality. London, Hutchinson.

Galavotti, C., K. A. Pappas-DeLuca and A. Lansky (2001). "Modeling and Reinforcement to Combat HIV: The MARCH Approach to Behavior Change." Am J Public Health **91**(10): 1602-1607.

Gallo, M. F., H. Gebreselassie, M. T. Victorino, M. Dgedge, L. Jamisse and C. Bique (2004). "An assessment of abortion services in public health facilities in Mozambique: women's and providers' perspectives." Reprod Health Matters **12**(24 Suppl): 218-26.

Garcia-Moreno, C. and C. Watts (2000). "Violence against women: its importance for HIV/AIDS." AIDS **14**(Suppl 3): S253-65.

Garcia, P. M. K., Leslie A.; Pitt, Jane; et al. (1999). "Maternal Levels of Plasma Human Immunodeficiency Virus Type I RNA and the Risk of Perinatal Transmission." New England Journal of Medicine **341**(6): 394.

Gausset, Q. (2001). "AIDS and cultural practices in Africa: the case of the Tonga (Zambia)." Soc Sci Med **52**(4): 509-18.

Gengenbach, H. (2002). "Boundaries of Beauty: Tattooed Secrets of Women's History in Magude District, Southern Mozambique." Journal of Women's History **Winter**: 106-141.

Gerrits, T. (1997). "Social and cultural aspects of infertility in Mozambique." Patient Education and Counseling **31**(1): 39-48.

Giami, A. and G. Dowsett (1996). "Social research on sexuality: contextual and interpersonal approaches." AIDS **10**(Suppl A): S191-6.

Giddens, A. (1990). The consequences of modernity. Cambridge, Polity in association with Blackwell.

Giddens, A. (1991). Modernity and self identity: self and society in the late modern age. Cambridge, Polity Press in association with Basil Blackwell.

Giddens, A. (1999). "The Reith Lectures." Retrieved June 21, 1999.

Gielen, A. C., R. R. Faden, P. O'Campo, N. Kass and et al. (1994). "Women's protective sexual behaviors: A test of the Health Belief Model." AIDS Education & Prevention **6**(1): 1-11.

Giffin, K. and C. M. Lowndes (1999). "Gender, sexuality, and the prevention of sexually transmissible diseases: a Brazilian study of clinical practice." Soc Sci Med **48**(3): 283-92.

Gil, V. E. (1991). "An Ethnography of HIV AIDS and Sexuality in the Peoples-Republic-of-China." Journal of Sex Research **28**(4): 521-537.

Gilmore, S., J. DeLamater and D. Wagstaff (1996). "Sexual decision making by inner city black adolescent males: A focus group study." Journal of Sex Research **33**(4): 363-371.

Glanz, K., F. M. Lewis and B. Rimmer, Eds. (1990). Health Behavior and Health Education: Theory, Research and Practice. San Francisco, Jossey-Bass Publishers.

Goffman, E. (1959). The Presentation of Self in Everyday Life. Garden City, New York, Doubleday.

Granja, A. C., F. Machungo, A. Gomes and S. Bergstrom (2001). "Adolescent maternal mortality in Mozambique." J Adolesc Health **28**(4): 303-6.

Graveline, C., J. Robert and R. Thomas (1998). Les préjugés plus forts que la mort: le sida au Québec. Montréal, Vlb.

Green, E. C. (1994). "AIDS and STDs in Africa: bridging the gap between traditional healing and modern medicine." Boulder, Colorado/Oxford, England, Westview Press **276**.

Green, E. C. (1996). "Purity, pollution and the invisible snake in southern Africa." Med-Anthropol **17**(1): 83-100.

Green, E. C. (1997). "The participation of African traditional healers in AIDS STD prevention programmes." Tropical Doctor **1**: 56-9.

Green, E. C., A. Jurg and A. Dgedge (1993). "Sexually-transmitted diseases, AIDS and traditional healers in Mozambique." Medical Anthropology **15**(3): 261-81.

Green, E. C., B. Zokwe, J. D. Dupree and J. Marrato (1995). AIDS STD prevention programs that rely on South African and Mozambican traditional healers, [Unpublished] 1995. Presented at the Third USAID HIV / AIDS Prevention Conference Washington D.C. August 7-9 1995. 5 p.

Green, L. and M. Kreuter (1991). Health Promotion and Planning: An Education and Environmental Approach, Mayfield Publishing.

Greenberg, J. (1996). AIDS Education: Interventions in Multicultural settings. New York, Plenum Press.

GRM. (2001). "Mozambique Web." Retrieved 3/27/2001 3:14:02 PM, 2001, from http://www.mozambique.mz/saude/aids/index.htm.

Grosskurth, H., F. Mosha, J. Todd, E. Mwijarubi, A. Klokke, K. Senkoro, P. Mayaud, J. Changalucha, A. Nicoll and G. ka-Gina et al (1995a). "Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania: randomised controlled trial." Lancet **346**(August 26): 530-536.

Grosskurth, H., F. Mosha, J. Todd, K. Senkoro, J. Newell, A. Klokke, J. Changalucha, B. West, P. Mayaud, A. Gavyold, R. Gabone, D. Mabey and R. Hayes (1995b). "A community trial of the impact of improved sexually transmitted disease treatment on the HIV epidemic in rural Tanzania: 2. Baseline survey results." AIDS 1995 **Volume 9**.

Grove, K. A., D. Kelly and J. Liu (1997-1998). ""But Nice Girls Don't Get It"." Journal of Contemporary Ethnography **26**: 317-337.

Halperin, D. T. and R. C. Bailey (1999). "Male circumcision and HIV infection: 10 years and counting." Lancet **354**(9192): 1813-5.

Hardy, E., A. Bugalho, A. Faundes, G. A. Duarte and C. Bique (1997). "Comparison of women having clandestine and hospital abortions: Maputo, Mozambique." Reproductive Health Matters **5**(9): 108-15.

Hargreaves, J. R., M. A. Collinson, K. Kahn, S. J. Clark and S. M. Tollman (2004). "Childhood mortality among former Mozambican refugees and their hosts in rural South Africa." Int J Epidemiol **33**(6): 1271-8.

Hargreaves, J. R. and J. R. Glynn (2002). "Educational attainment and HIV-1 infection in developing countries: a systematic review." Tropical Medicine and International Health **7**(6): 489-498.

Harries, P. (1994). Work, Culture and Identity, migrant laborers in Mozambique and South Africa, c. 1860 - 1910. Cape Town, UCT.

Harrison, A., M. Lurie and N. Wilkinson (1997a). "Exploring partner communication and patterns of sexual networking: qualitative research to improve management of sexually transmitted diseases." Health Transit Rev **3**: 103-7.

Harrison, A., M. Lurie and N. Wilkinson (1997b). "Exploring partner communication and patterns of sexual networking: qualitative research to improve management of sexually transmitted diseases." Health Transit Rev **7 Suppl 3**: 103-7.

Harrison, A. and E. Montgomery (2001). "Life Histories, Reproductive Histories: Rural South African Women's Narratives of Fertility, Reproductive Health and Illness." Journal of Southern African studies **27**(2): June.

Hawkins, K. and B. Meshesha (1994). Reaching young people: Ingredients of effective programmes. Population policies reconsidered: Health, empowerment and rights. A. G. a. L. C. C. G. Sen. Cambridge, Harvard Centre for Population and Development Studies**:** 211-22.

Hays, R., S. Kegeles and T. Coates (1990). "High HIV risk-taking among young gay men." AIDS **4**: 901-7.

Heald, S. (1995). "The power of sex: some reflections on the Caldwells' 'African sexuality' thesis." Africa **65**(4): 489-505.

Hearst, N., J. S. Mandel and T. J. Coates (1995). "Collaborative AIDS prevention research in the developing world: the CAPS experience." AIDS **9**(suppl 1): S1-S5.

Heinrich, L. B. (1993). "Contraceptive self-efficacy in college women." J-Adolesc-Health **14**(4): 269-76.

Heise, L. (1993). "Violence against women: the hidden health burden." World Health Stat Q **46**(1): 78-85.

Heise, L., K. A. Moore and N. Toubia (1995). Sexual coercion and reproductive health: a focus on research. New York, Population Council**:** 59.

Hingson, R., L. Strunin, B. Berlin and T. Heeren (1990). "Beliefs about AIDS, use of alcohol and drugs, and unprotected sex among Massachusetts adolescents." American Journal of Public Health **80**(3): 295-299.

Hogle, J., E. Green, V. Nantulya, R. Stoneburner and J. Stover (2002). What happened in Uganda? Declining HIV prevalence, behavior change, and the national response. Washington, D.C., TvT Associates, Synergy Project**:** 13.

Holland, J. (1991). Pressure, resistance, empowerment: young women and the negotiation of safer sex. London, Tufnell Press [for] Women Risk and AIDS Project.

Holland, J., C. Ramazanoglu, S. Scott, S. Sharpe and R. Thomson (1990). "Sex, Gender and Power: Young women's sexuality in the shadow of AIDS." Sociology of Health and Illness **12**(3): 336-351.

Holland, J., C. Ramazanoglu, S. Scott, S. Sharpe and R. Thomson (1991). Between embarrassment and trust: Young women and the diversity of condom use. AIDS: Responses, interventions and care. P. Aggleton, G. Hart and P. Davies. London; New York, Falmer Press: 127-148.

Holland, J., C. Ramazanoglu, S. Scott, S. Sharpe and R. Thomson (1992). "Pleasure, pressure and power: some contradictions of gendered sexuality." Sociological review **40**: 645-674.

Holland, J., C. Ramazanoglu, S. Sharpe and R. Thomson (1994). Becoming a 'real' man: The social construction of masculine sexuality. AIDS: Setting a feminist agenda. L. Doyal, J. Naidoo and T. Wilton. London, Falmer.

Holtgrave, D. R., N. L. Qualls, J. W. Curran, R. O. Valdiserri, M. E. Guinan and W. C. Parra (1995). "An overview of the effectiveness and efficiency of HIV prevention programs." Public Health Report **110**: 134-146.

Howard, M. and J. B. McCabe (1990). "Helping teenagers postpone sexual involvement." Family Planning Perspectives **22**: 21-6.

Hynie, M., J. E. Lydon, S. Cote and S. Wiener (1998). "Relational sexual scripts and women's condom use: The importance of internalized norms." Journal of Sex Research **35**(4): 370-380.

Ickovics, J. R., A. C. Morrill, S. E. Beren, U. Walsh and et al. (1994). "Limited effects of HIV counseling and testing for women: A prospective study of behavioral and psychological consequences." Jama: Journal of the American Medical Association **272**(6): 443-448.

Ingham, R., E. Jaramazovic, D. Stevens, I. Vanwesenbeeck and G. van Zessen (1996). Protocol for comparative qualitative studies on sexual conduct and HIV risks. Southampton, Centre for Sexual Health Research, Faculty of Social Sciences, University of Southampton: 148.

Ingham, R. and G. van Zessen (1992). Towards an alternative model of sexual behaviour: from individual properties to interactional processes. Southampton, EC concerted action on sexual behaviour and the risks of HIV infection.

Ingham, R. and G. van Zessen (1997). From Individual Properties to Interactional Processes. Sexual Interactions and HIV Risk: New Conceptual Perspectives in European Research. L. van Campenhoudt, M. Cohen, G. Guizzardi and D. Hausser. London, Taylor & Francis: 83-99.

Inhorn, M. C. and K. L. Whittle (2001). "Feminism meets the "new" epidemiologies: toward an appraisal of antifeminist biases in epidemiological research on women's health." Soc Sci Med **53**(5): 553-67.

Jackson, P. A. (1997). The historical emergence of gay male identity in Thailand. Sites of Desire/Economies of Pleasure: Sexualities in the Asia and Pacific. L. Manderson and M. Jolley. Chicago and London, University of Chicago Press: 166-190.

James, N. J., C. J. Bignell and P. A. Gillies (1991). "The reliability of self-reported sexual behaviour." AIDS **5**(3): 333-6.

Jamisse, L., F. Songane, A. Libombo, C. Bique and A. Faundes (2004). "Reducing maternal mortality in Mozambique: challenges, failures, successes and lessons learned." Int J Gynaecol Obstet **85**(2): 203-12.

Janz, N. K. and M. H. Becker (1984). "The health belief model: A decade later." Health Education Quarterly **11**: 1-47.

Jemmott, J. B., 3rd, L. S. Jemmott and G. T. Fong (1992). "Reductions in HIV risk-associated sexual behaviors among black male adolescents: effects of an AIDS prevention intervention." Am J Public Health **82**(3): 372-7.

Jemmott, J. B. d., L. W. Jemmott, H. Spears, N. Hewitt and M. Cruz-Collins (1992). "Self-efficacy, hedonistic expectancies, and condom-use intentions among inner-city black adolescent women: a social cognitive approach to AIDS risk behavior." J Adolesc Health **13**(6): 512-9.

Jenkins, P. (2000a). "City profile: Maputo." Cities **17**(3): 207-218.

Jenkins, P. (2000b). "Urban management, urban poverty and urban governance: planning and land management in Maputo<BR>." Environment and urbanization **12**(2): 137-152.

Job, R. F. S. (1988). "Effective and ineffective use of fear in health promotion campaigns." American Journal of Public Health **78**: 163-7.

Johnson, R. B. (1997). "Examining the validity structure of qualitative research." Education **118**(2): 282-292.

Jones, C. and R. Porter (1994). Reassessing Foucault: power, medicine and the body. London, Routledge.

Junod, H. (1962 [1912]). The Life of a South African Tribe: I. Social Life. New Hude Park, New York [Neuchatel, CH], University Books [Attinger Bros].

Kalichman, S. C. and L. C. Simbayi (2003). "HIV testing attitudes, AIDS stigma, and voluntary HIV counselling and testing in a black township in Cape Town, South Africa." Sex Transm Infect **79**(6): 442-7.

Kalichman, S. C. and L. Y. Stevenson (1997). "Psychological and social factors associated with histories of risk for human immunodeficiency virus infection among African-American inner- city women." J Womens Health **6**(2): 209-17.

Kane, R. and K. Wellings (1999). "Integrated sexual health services: the views of medical professionals." Culture Health Sexuality **1**(2): 131-45.

Karlyn, A. S. (1998a). "Health-risk targeting in Mozambique." Integration **58**: 32-4.

Karlyn, A. S. (1998b). Inter-Personal Communications for Behavior Change: A Targeted Approach to AIDS Prevention. Geneva, Paper presented at the X International Conference on STD/AIDS, Satelite Meeting for Social Marketing, Population Services International.

Karlyn, A. S. (2001). "The impact of a targeted radio campaign to prevent STIs and HIV/AIDS in Mozambique." AIDS Educ Prev **13**(5): 438-51.

Karlyn, A. S. (2005). "Intimacy revealed: Sexual experimentation and the construction of risk among young people in Mozambique." Culture Health and Sexuality **7**(3): 279-292(14).

Karlyn, A. S., J. da Silva and M. Duce (1994). Rapid Nutritional Survey: Periurban Maputo. Maputo, MZ, Medecins Sans Frontieres (CIS/Espanha).

Karlyn, A. S. and P. M. Monjane (1998). National AIDS Prevention Survey (NAPS) of Mozambican Sexual Behaviors and Condom Use - Final Report. Maputo, MZ, Population Services International, Mozambique National AIDS Control Program: 49.

Karlyn, A. S. and F. Mussa (2000). Youth In and Out of School in the City of Maputo: A Qualitative Study of High-Risk Groups. Maputo MZ, Population Services International in Mozambique, Mozambique National AIDS Control Program, London School of Hygiene and Tropical Medicine: Centre for Population Studies.

Kasen, S., R. D. Vaughan and H. J. Walter (1992). "Self-efficacy for AIDS preventive behaviors among tenth grade students." Health Education Quarterly **19**(2): 187-202.

Kaufman, C. E., T. de Wet and J. Stadler (2001). "Adolescent pregnancy and parenthood in South Africa." Stud Fam Plann **32**(2): 147-60.

Kegeles, S., R. Hays and T. Coates (1996). "The Mpowerment Project: a community-level HIV prevention intervention for young gay men." Am J Public Health **86**: 1129-36.

Keller, M. L. (1993). "Why don't young adults protect themselves against sexual transmission of HIV? Possible answers to a complex question." AIDS Education & Prevention **5**(3): 220-233.

Kelly, J., D. Murphy, K. Sikkema and et al (1997). "Randomized, controlled, community-level HIV-prevention intervention for sexual-risk behavior among homosexual men in U.S. cities. Community HIV Prevention Research Collaborative." Lancet **350**: 1500-5.

Kelly, J. A. (1999). "Community-Level Interventions Are Needed to Prevent new HIV Infections -- Editorial." American Journal of Public Health **89 (March)**(3): 299-301.

Kelly, J. A., D. A. Murphy, K. J. Sikkema and S. C. Kalichman (1993). "Psychological interventions to prevent HIV infection are urgently needed: New priorities for behavioral research in the second decade of AIDS." American Psychologist **48**(10): 1023-1034.

Kelly, J. A., K. J. Sikkema and D. R. Holtgrave (1989). Community outreach and education. Sexually Transmitted Diseases. K. Holmes. New York, McGraw-Hill: 1323-8.

Kendall, C. (1995). The Construction of Risk in AIDS Control Programs: Theoretical Bases and Popular Responses. Conceiving Sexuality: Approaches to Sex Research in a Postmodern World. R. Parker and J. Gagnon. New York, Routledge: 249-58.

Keogh, P., S. Beardswell and S. Research (1997). Sexual Negotiation Strategies of HIV-Positive Gay men: a Qualitative Approach. AIDS: activism and alliances. P. Aggleton, P. M. Davies and G. Hart. London; Washington, DC, Taylor & Francis: 226-237.

King, A. J. C. and N. P. Wright (1991). The design of HIV risk-reduction interventions: An analysis of barriers and facilitators. Geneva, World Health Organization.

Kinsey, A. C. (1953). Sexual behavior in the human female. Philadelphia; London, Saunders.

Kinsey, A. C., W. B. Pomeroy and C. E. Martin (1948). Sexual behavior in the human male. Philadelphia; London, Saunders.

Kinsman, J., S. Nyanzi and R. Pool (2000). "Socializing influences and the value of sex: the experience of adolescent school girls in rural Masaka, Uganda." Culture, Health & Sexuality **2**(2): 151-166.

Kippax, S., J. Crawford, M. Davis, P. Rodden and et al. (1993). "Sustaining safe sex: A longitudinal study of a sample of homosexual men." AIDS **7**(2): 257-263.

Kirby, D. (1984). Sexuality education: an evaluation of programs and their effects. Santa Cruz, CA, Santa Cruz, California, Network Publications: 457.

Kirby, D. (1992). School-based prevention programs: Design, evaluation, and effectiveness. Adolescents and AIDS: A Generation in Jeopardy. R. J. DiClemente. Newbury Park, CA, Sage.

Kirby, D. and R. J. DiClemente (1994). "School-based interventions to prevent unprotected sex and HIV among adolescents." In: Preventing AIDS: theories and methods of behavioral interventions, edited by Ralph J DiClemente and John L Peterson New York, New York, Plenum Press: 117-39.

Kirsch, J. R. (1989). "Comprehension amd memory of a sexual script: A test of schema/scripting theory." Dissertation Abstracts International **50**(5-B): 2155.

Kitzinger, J. (1994). Focus groups: Method or madness? Challenge and innovation: Methodological advances in social research on HIV/AIDS. B. Mary, Taylor & Francis, London, England: 159-175.

Kitzinger, J. (1995). "'I'm sexually attractive but I'm powerful': Young women negotiating sexual reputation." Women's Studies International Forum **18**: 1-8.

Kleinman, A. (1980). Patients and Healers in the Context of Culture. Berkeley, CA, University of California Press.

Kline, A., E. Kline and E. Oken (1992). "Minority women and sexual choice in the age of AIDS." Soc Sci Med **34**(4): 447-57.

Knodel, J., M. VanLandingham, C. Saengtienchai and A. Pramualratana (1996). "Thai views of sexuality and sexual behaviour." Health transition review **6**(2): 179-201.

Koenig, M. A., I. Zablotska, T. Lutalo, F. Nalugoda, J. Wagman and R. Gray (2004). "Coerced first intercourse and reproductive health among adolescent women in Rakai, Uganda." Int Fam Plan Perspect **30**(4): 156-63.

Kok, G. (1991). "Planned health education and the role of self-efficacy: Dutch research." Health Education Research, Eynsham **6**(2): 231-238.

Konings, E., G. Bantebya, M. Carael and D. Bagenda (1995). "Validating population surveys for the measurement of HIV/STD prevention indicators." AIDS **9**(4): 375-382.

Krol, J. F. (1990). "Restroom to tearoom, a cultural conversion: a note on Humphreys, Delph, and Swidler." Deviant Behavior **11**: 273-80.

Kvalem, I. L. and B. Traeen (2000). "Self-efficacy, scripts of love and intention to use condoms among Norwegian adolescents." Journal of Youth and Adolescence **29**(3): 337-353.

Kyes, K. B., I. S. Brown and R. H. Pollack (1991). "The effect of exposure to a condom script on attitudes toward condoms." Journal of Psychology and Human sexuality **4**(21-36).

Lambevsky, S. A. (1999). "Suck My Nation: Masculinity, Ethnicity and the Politics of (Homo)sex." Sexualities **2**(4): 397-419.

Lamptey, P. R., M. C. Kamenga and S. S. Weir (1997). "Prevention of sexual transmission of HIV in sub-Saharan Africa: lessons learned." AIDS **11**(suppl B): S63-S77.

Lancet (2000). "Politicisation of debate on HIV care in South Africa - Editorial." Lancet **355**: 1473.

Lane, J. M. (1993). "Surveys, surveillance, and the measurement of risk: a response to Herbert Smith." Health transition review **3**(2): 208-11.

LaPlante, M. N., N. McCormick and G. G. Brannigan (1980). "Living the sexual script: College students' views of influence in sexual encounters." Journal of Sex Research **16**(4): 338-355.

Laub, C., D. M. Somera, L. K. Gowen and R. M. Diaz (1999). "Targeting "risky" gender ideologies: constructing a community-driven, theory-based HIV prevention intervention for youth." Health-Educ-Behav **26**(2): 185-99.

Lauman, E. O. and J. H. Gagnon (1995). A Sociological Perspective on Sexual Action. Conceiving Sexuality: Approaches to Sex Research in a Postmodern World. R. Parker and J. H. Gagnon. New York, Routledge: 183-213.

Lear, D. (1995). "Sexual communication in the age of AIDS: the construction of risk and trust among young adults." Soc Sci Med **41**(9): 1311-23.

Lear, D. (1996). "'You're gonna be naked anyway': college students negotiating safer sex." Qualitative Health Research **6**(1): 112-134.

Leclerc-Madlala, S. (2001). "Virginity testing: managing sexuality in a maturing HIV/AIDS epidemic." Med Anthropol Q **15**(4): 533-52.

Leclerc-Madlala, S. (2002). "Youth, HIV/AIDS and The Importance of Sexual Culture and Context." Social Dynamics **28**(1): 20-41.

LeFranc, E., G.E. Wyatt, C. Chambers, D. Eldemire, B. Bain, H. Ricketts (1996). "Working women's sexual risk taking in Jamaica." Social Science and Medicine **42**(10): 1411-1417.

Leigh, B. C., B. Aramburu and J. Norris (1992). "The morning after: Gender differences in attributions about alcohol-related sexual encounters." Journal of Applied Social Psychology **22**: 343-357.

Leshabari, M. T. and S. F. Kaaya (1997). "Bridging the information gap: sexual maturity and reproductive health problems among youth in Tanzania." Health transition review **3**: 29-44.

Lesko, N. (1996). "Denaturalizing Adolescence: The politics of contemporary representations." Youth and Society **28**: 139-161.

Levanthal, H. (1970). Findings and theory in the study of fear communications. Advances in Experimental Social Psychology. L. Berkowitz. New York, Academic Press. **5**.

Liljestrand, J., S. Bergstrom, F. Nieuwenhuis and B. Hederstedt (1985). "Syphilis in pregnant women in Mozambique." Genitourinary medicine **61**: 355-358.

Lincoln, Y. S. and N. K. Denzin (2000). Handbook of qualitative research. Thousand Oaks, Calif., London, Sage Publications.

Lincoln, Y. S. and E. G. Guba (1985). Naturalistic inquiry. Beverly Hills, Calif.; London, Sage.

Lindan, C. S. A. M. C., et al. (1991). "Knowledge, attitudes, and perceived risk of AIDS among urban Rwandan women: relationship to HIV infection and behavior change." AIDS **5**(8): 993-1002.

Lindsey, B. J. (1997). "Peer education: a viewpoint and critique see comments." J-Am-Coll-Health **45**(4): 187-9.

Liotta, G. and et al (2002). "HIV infection in Northern Mozambique." South African Medical Journal **92**(1): 12-3.

Liquela, R. M. M. (1996). Sexually transmitted diseases: health seeking behavior, knowledge, attitudes, and practices among women factory workers and street-based commercial sex workers in Maputo, Mozambique / by Rosa Marlene Manjate Liquela.

Longmore, M. A. (1998). "Symbolic interactionism and the study of sexuality." Journal of Sex Research **35**(1): 44-57.

Lottes, I. L. (1993). "Nontraditional gender roles and sexual experience of heterosexual college students." Sex Roles **29**: 645-669.

Low-Beer, D. (2003). "Behaviour and communication change in reducing HIV: is Uganda unique?" African Journal of AIDS Research **2**(1): 9-21.

Lundin, I. B. (2000). "Africa Watch Will Mozambique remain a success story?" African Security Review **9**(3): 79.

Lurie, M. N., B. G. Williams, K. Zuma, D. Mkaya-Mwamburi, G. Garnett, A. W. Sturm, M. D. Sweat, J. Gittelsohn and S. S. Abdool Karim (2003). "The impact of migration on HIV-1 transmission in South Africa: a study of migrant and nonmigrant men and their partners." Sex Transm Dis **30**(2): 149-56.

Mac-Arthur, A., S. Gloyd, P. Perdigao, A. Noya, J. Sacarlal and J. Kreiss (2001). "Characteristics of drug resistance and HIV among tuberculosis patients in Mozambique." Int J Tuberc Lung Dis **5**(10): 894-902.

Machel, J. Z. (2001). "Unsafe sexual behaviour among schoolgirls in Mozambique: a matter of gender and class." Reprod Health Matters **9**(17): 82-90.

MacPhail, C. (2003). "Challenging dominant norms of masculinity for HIV prevention." African Journal of AIDS Research **2**(2): 141–149.

MacPhail, C. and C. Campbell (2001). "'I think condoms are good but, aai, I hate those things': condom use among adolescents and young people in a Southern African township." Soc Sci Med **52**(11): 1613-1627.

MacPhail, C., B. G. Williams and C. Campbell (2002). "Relative risk of HIV infection among young men and women in a South African township." Int J STD AIDS **13**(5): 331-42.

Madden, T. J., P. S. Ellen and I. Ajzen (1992). "A comparison of the theory of planned behavior and the theory of reasoned action." Personality & Social Psychology Bulletin **18**(1): 3-9.

Maibach, E. W., J. A. Flora and C. Nass (1991). "Changes in self-efficacy and health behavior in response to a minimal contact community health campaign." Health Communication **3**: 1-15.

Malungo, J. (2001). "Sexual cleansing (Kusalazya) and levirate marriage (Kunjilila mung'anda) in the era ofAIDS: changes in perceptions and practices in Zambia." Social Science & Medicine **53**: 371-82.

Maman, S., J. Campbell, M. D. Sweat and A. C. Gielen (2000). "The intersections of HIV and violence: directions for future research and interventions." Soc Sci Med **50**(4): 459-78.

Maman, S., J. K. Mbwambo, N. M. Hogan, E. Weiss, G. P. Kilonzo and M. D. Sweat (2003). "High rates and positive outcomes of HIV-serostatus disclosure to sexual partners: reasons for cautious optimism from a voluntary counseling and testing clinic in Dar es Salaam, Tanzania." AIDS Behav **7**(4): 373-82.

Manderson, L., L. R. Bennett and M. Sheldrake (1999). "Sex, social institutions, and social structure: anthropological contributions to the study of sexuality." Annu Rev Sex Res **10**: 184-209.

Mann, J. M., S. S. Fluss and World Health Organization. (1991). Legislative responses to AIDS. Dordrecht, London, Nijhoff.

Mann, J. M., D. Tarantola and T. W. Netter (1992). AIDS in the world. Cambridge, Mass, Harvard University Press.

Manuel, S. (2005). "Obstacles to condom use among secondary school students in Maputo city, Mozambique." Culture, Health & Sexuality **7**(3): 293-302.

Masauso, N.-M., K. Romano, S. Anyangwe, J. Wiseman, M. Macwan'gi, C. Kendall and E. C. Green (1996). "A targetted intervention research on traditional healer perspectives of sexually transmitted illnesses in urban Zambia. Current research." Societes D'Afrique Et Sida(13): 7.

Mason, K. O. (1994). "HIV transmission and the balance of power between women and men: a global view." Health transition review **4**: 217-240.

Maticka-Tyndale, E. (1991). "Sexual Scripts and AIDS Prevention - Variations in Adherence to Safer-Sex Guidelines By Heterosexual Adolescents." Journal of Sex Research **28**(1): 45-66.

Mbizvo, M. T., A. S. Latif, R. Machekano, W. MacFarland, M. T. Bassett, S. Ray and D. Katzenstein (1997). "HIV seroconversion among factory workers in Harare: who is getting newly infected?" Cent-Afr-J-Med **43**(5): 135-9.

Mbofana, F. S., F. J. Brito, A. Saifodine and J. L. Cliff (2002). "Syndromic management of sexually transmitted diseases at primary care level, Mozambique." Sex Transm Infect **78**(1): E2.

McCamish, M., G. Storer and G. Carl (2000). "Refocusing HIV/AIDS interventions in Thailand: the case for male sex workers and other homosexually active men." Culture, Health & Sexuality **2**(2): 167-182.

McCool, J. P., L. D. Cameron and K. J. Petrie (2001). "Adolescent perceptions of smoking imagery in.lm." Social Science & Medicine **52**: 1577–1587.

McGrath, J. W., C. B. Rwabukwali, D. A. Schumann, J. Pearson-Marks, S. Nakayiwa, B. Namande, L. Nakyobe and R. Mukasa (1993). "Anthropology and AIDS: the cultural context of sexual risk behavior among urban Baganda women in Kampala, Uganda." Soc Sci Med **36**(4): 429-39.

McKirnan, D. J., D. G. Ostrow and B. Hope (1996). "Sex, drugs and escape: a psychological model of HIV-risk sexual behaviours." AIDS-Care **8**(6): 655-69.

McKusick, L., T. J. Coates, S. F. Morin, L. Pollack and C. Hoff (1990). "Longitudinal predictors of reductions in unprotected anal intercourse among gay men in San Francisco: the AIDS Behavioral Research Project." Am-J-Public-Health **80**(8): 978-83.

McLaws, M. L., B. Oldenburg, M. W. Ross and D. A. Cooper (1990). "Sexual-Behavior in AIDS-Related Research - Reliability and Validity of Recall and Diary Measures." Journal of Sex Research **27**(2): 265-281.

McLeroy, K. R., D. Bibeau, A. Stckler and K. Glanz (1988). "An Ecological Perspective on Health Promotion Programs." Health Education Quarterly **15**: 351-77.

Meekers, D. and A. E. Calves (1997). "'Main' girlfriends, girlfriends, marriage, and money: the social context of HIV risk behaviour in sub-Saharan Africa." Health Transit Rev **7 Suppl**: 361-75.

Meekers, D. and A. E. Calvès (1997). "'Main' girlfriends, girlfriends, marriage, and money: the social context of HIV risk behaviour in sub-Saharan Africa." Health Transit Rev **7**(Suppl): 361-375.

Meekers, D. and M. Klein (2002). "Understanding gender differences in condom use self-efficacy among youth in urban Cameroon." AIDS Educ Prev **14**(1): 62-72.

Meischke, H. (1995). "Implicit Sexual Portrayals in the Movies - Interpretations of Young-Women." Journal of Sex Research **32**(1): 29-36.

Meursing, K. (1997). A World of Silence: Living with HIV in Matabeleland, Zimbabwe. Amsterdam, Royal Tropical Institute (KIT).

Michie, S. and C. Abraham (2004). "Identifying techniques that promote health behaviour change: Evidence based or evidence inspired?" Psychology and Health **19**: 29-49.

Middlestadt, S. E., K. Bhattacharyya, J. Rosenbaum, M. Fishbein and M. Shepherd (1996). "The use of theory based semistructured elicitation questionnaires: formative research for CDC's Prevention Marketing Initiative." Public Health Rep **111**(Suppl 1): 18-27.

Middlethon, A.-L. (1997). Sexual Debut and the Risk of HIV Infection among Young Gay Men in Norway. AIDS: activism and alliances. P. Aggleton, P. M. Davies and G. Hart. London; Washington, DC, Taylor & Francis: 100-121.

MISAU (1998). *Programa nacional de combate ao SIDA* [National Programme for the Combat Against AIDS]. Maputo, MZ, Ministry of Health (Ministério de Saúde).

Moatti, J.-P., D. Hausser and D. Agrafiotis (1997). Understanding HIV Risk-related Behaviour: A Critical Overview of Current Models. Sexual Interactions and HIV Risk: New

Conceptual Perspectives in European Research. L. van Campenhoudt, M. Cohen, G. Guizzardi and D. Hausser. London, Taylor & Francis: 100-126.

Mofenson, L. M. L., John S.; Stiehm, E. Richard; et al. (1999). "Risk Factors for Perinatal Transmission of Human Immunodeficiency Virus Type I in Women Treated With Zidovudine." New England Journal of Medicine **341**(6): 385.

MoH (1997). Training and Reference Manual for Peer Educators for the Prevention of STD/AIDS. MISAU, MONASO and PSI. Maputo, Ministry of Health, National Program for the Control of STD/AIDS, Health Education Unit, MONASO, Population Services International (PSI): 52.

MoH (1998). National Program to Combat AIDS. Maputo, Ministry of Health.

MoH (2000). National strategic plan to combat STD/HIV/AIDS: Integration, quality and coverage. Maputo, Ministry of Health.

MoH (2001). The Demographic impact of HIV/AIDS in Mozambique. Maputo, Mozambique, Ministry of Health, Ministry of Planning, and Center for Population Studies of Eduardo Mondlane University.

MoH (2003). Report on the Revision of Epidemiological Surveillance of HIV Data - Round 2002. Maputo, MZ, GRM, MoH, DNS, PNC DTS/HIV-SIDA, Technical Group for the Multisectoral Support for the Fight Against HIV/AIDS in Mozambique: 44.

MoH (2004). National strategic plan (NSP) to combat HIV/AIDS for the period of 2004-2008. Maputo, Ministry of Health.

Mohamed, A. and J. Pacca (2002a). Adolescents in Mozambique: a qualitative approach to analyze their vulnerability to HIV/AIDS. Paper presented at the 14th International AIDS Conference, Barcelona, Spain.

Mohamed, A. and J. Pacca (2002b). CAP Study on Truck Drivers in Maputo/Mozambique: prevention roadblocks in a group passing through high-prevalence zones. Paper presented at the 14th International AIDS Conference, Barcelona, Spain.

Mondlane, J. (2002). Mozambique: Strategy for the campaign against HIV/AIDS. Paper presented at the 14th International AIDS Conference, Barcelona, Spain.

Monjane, P., C. Uamusse, C. Osório, T. C. e. Silva and X. Andrade (2003). A Cultural View of the Prevention and Mitigation of HIV/AIDS: The Experience of Mozambique. A case

study with youth from the southern region of the country: Massinga, Maxixe, Chókwe, Xai-Xai, Matola, Moamba and Maputo City (Districts 1 and 2). Maputo City, MZ, Foundation for Community Development. AIDS and Development Unit. Project Kuhluvuka - Corridors of Hope.

Moore, S. and D. Rosenthal (1992). "The social context of adolescent sexuality: safe sex implications." Journal of Adolescence **15**: 415-435.

Morgan, D. L. (1988). Focus groups as qualitative research. London, Sage.

Morrell, R. (2000). Changing Masculinities in a Changing Society Men and Gender in Southern Africa.

Morrell, R. (2001). Changing men in Southern Africa. Pietermaritzburg/London, University of Natal Press: Zed Books.

Morris, L., E. Mazive, N. Prata, A. Vergara, R. Badiani, A. Honwana and A. Balate (2002). Sexual Behavior of Young Adults and Knowledge of HIV/AIDS in Mozambique: Preliminary Report. Atlanta, GA, CDC.

Morse, J. M., M. Barrett, M. Mayan, K. Olson and J. Spiers (2002). "Verification strategies for establishing reliability and validity in qualitative research." International Journal of Qualitative Methods **1**(2): Article 2.

Mosher, D. L. and P. Macian (1994a). "College Men and Women Respond to X-Rated Videos Intended For Male or Female Audiences - Gender and Sexual Scripts." Journal of Sex Research **31**(2): 99-113.

Mosher, D. L. and P. MacIan (1994b). "College men and women respond to X-rated videos intended for male or female audiences: Gender and sexual scripts." Journal of Sex Research **31**(2): 99-113.

Mosher, D. L. and S. S. Tomkins (1988). "Scripting the Macho Man - Hypermasculine Socialization and Enculturation." Journal of Sex Research **25**(1): 60-84.

Mozambique (1998). Living Standards Measurments Survey (LSMS) - 1996/1997 [Inquérito Nacional aos Agregados Familiares sobre Condições de Vida 1996/1997]. Maputo, National Institute of Statistics [Instituto Nacional de Estatística].

Mozambique Census (1997). II General Census of Population and Households [II Recenceamento Geral da População e Habitação]. Maputo, Instituto Nacional de Estatística.

Mukodzani, L., K. S. Mupemba and J. Marck (1999). All roads lead to Harare: the response of the Zimbabwe transport industry to HIV/AIDS. The Continuing African HIV/AIDS Epidemic. J. Caldwell, I. Orubuloye and J. Ntozi. Canberra ACT Australia, Health Transition Centre Books, Health Transition Centre, National Centre for Epidemiology and Population Health, Australian National University.

Murray, S. O. and K. W. Payne (1989). The Social Classification of AIDS in American Epidemiology. The AIDS pandemic: a global emergency. R. Bolton. New York, Gordon and Breach: 23-36.

Muyinda, H., J. Nakuya, R. Pool and J. Whitworth (2003). "Harnessing the senga institution of adolescent sex education for the control of HIV and STDs in rural Uganda." AIDS Care **15**(2): 159-67.

Neuman, W. L. (2000). Social research methods: qualitative and quantitative approaches. Boston [Mass.]; London, Allyn and Bacon.

Newman, L. M. (2001). "HIV seroprevalence among military blood donors in Manica Province, Mozambique." Int J STD AIDS **12**(4): 278-9.

Ngugi, E. N., F. A. Plummer, J. N. Simonsen, D. W. Cameron, M. Bosire, P. Waiyaki, A. R. Ronald and J. O. Ndinya-Achola (1988). "Prevention of transmission of human immunodeficiency virus in Africa: effectiveness of condom promotion and health education among prostitutes." Lancet **2**(8616): 887-90.

Ngugi, E. N., D. Wilson, J. Sebstad, F. A. Plummer and S. Moses (1996). "Focused peer-mediated educational programs among female sex workers to reduce sexually transmitted disease and human immunodeficiency virus transmission in Kenya and Zimbabwe." J Infect Dis **174**(2): S240-7.

Nnko, S., J. T. Boerma, M. Urassa, G. Mwaluko and B. Zaba (2004). "Secretive females or swaggering males? An assessment of the quality of sexual partnership reporting in rural Tanzania." Soc Sci Med **59**(2): 299-310.

Nnko, S. and R. Pool (1997). "Sexual discourse in the context of AIDS: dominant themes on adolescent sexuality among primary school pupils in Magu district, Tanzania." Health Transition Review **7**(Suppl 3): 85-90.

Noya, P. A., I.A. Nhatave, H. Tojais, S. Stakteas, K. Foreit, A. E. Vergara and A. Barreto (2002). Antenatal Clinic National HIV Surveillance in Mozambique: Variation in prevalence underscores different epidemics in the country. Paper presented at the 14th International AIDS Conference, Barcelona, Spain.

O'Leary, A. (1985). "Self-efficacy and health." Behavior Research Therapy **23**: 437-51.

O'Leary, A., F. Goodhart, L. S. Jemmott and L.-D. Boccher (1992). "Predictors of safer sex on the college campus: a social cognitive theory analysis." J-Am-Coll-Health **40**(6): 254-63.

O'Reilly, K. and P. Piot (1996). "International perspectives on individual and community approaches to the prevention of sexually transmitted disease and human immunodeficiency virus infection." J Infect Dis **174**(Supplement 2): S214-22.

O'Sullivan, L. F. and E. S. Byers (1992). "College-Students Incorporation of Initiator and Restrictor Roles in Sexual Dating Interactions." Journal of Sex Research **29**(3): 435-446.

Ogbuagu, S. C. and J. O. Charles (1993). "Survey of sexual networking in Calabar." Health transition review **3**: 105-19.

Ortiz-Torres, B., S. P. Williams and A. A. Ehrhardt (2003). "Urban women's gender scripts: implications for HIV prevention." Culture, Health & Sexuality **5**(1): 1 - 17.

Ortner, S. (1984). "Theory in anthropology since the sixties." Comparative Studies in Society and History **26**: 126-66.

Ortner, S. B. and H. Whitehead, Eds. (1981). Sexual Meanings: The Cultural Construction of Gender and Sexuality. New York, Cambridge University Press.

Orubuloye, I. O. (1994). Sexual networking and AIDS in Sub-Saharan Africa: behavioural research and the social context. Canberra, Australia, Health Transition Centre Australian National University.

Osman, N. B., K. Challis, E. Folgosa, M. Cotiro and S. Bergstrom (2000). "An intervention study to reduce adverse pregnancy outcomes as a result of syphilis in Mozambique." Sex Trans Inf **76**: 203-7.

Osullivan, L. F. and E. S. Byers (1993). "Eroding Stereotypes - College Womens Attempts to Influence Reluctant Male Sexual Partners." Journal of Sex Research **30**(3): 270-282.

Pacca, J. and A Mohamed (2002). Preparing for action: qualitative study for preventive intervention toward sex workers in Mozambique. Paper presented at the 14th International AIDS Conference, Barcelona, Spain.

Padez, C. (2003). "Age at menarche of schoolgirls in Maputo, Mozambique." Ann Hum Biol **30**(4): 487-95.

Paiva, V., J. R. Ayres and I. França Jr. (2004). "Expanding the flexibility of normative patterns in youth sexuality and prevention programs." Sexuality Research & Social Policy **1**(1): 1-15.

Parker, R. and J. Gagnon, Eds. (1995a). Conceiving Sexuality: Approaches to Sex Research in a Postmodern World. New York, Routledge.

Parker, R. and J. H. Gagnon (1995b). Conceiving Sexuality: Approaches to Sex Research in a Post-modern World, Routledge.

Parker, R. G. (1992). Sexual Diversity, Cultural Analysis, and AIDS Education in Brazil. The Time of AIDS: Social Analysis, Theory and Methods. G. Herdt and S. Lindenbaum. Newbury Park, CA, Sage**:** 225-242.

Parker, R. G. and M. Carballo (1990). "Qualitative Research On Homosexual and Bisexual Behavior Relevant to HIV AIDS." Journal of Sex Research **27**(4): 497-525.

Parker, R. G. and D. Easton (1998). "Sexuality, Culture, and Political Economy: Recent Developments in Anthropology and Cross Cultural Sex Research." Annual Review of Sex Research **9**: 1-19.

Parker, R. G., G. Herdt and M. Carballo (1991). "Sexual Culture, HIV Transmission, and AIDS Research." Journal of Sex Research **28**(1): 77-98.

Parkhurst, J. O. (2002). "The Ugandan success story? Evidence and claims of HIV-1 prevention." Lancet **360**(9326): 78-80.

Patton, M. Q. (1980). Qualitative evaluation methods. Beverley Hills, Sage.

Paul, E. L., B. McManus and A. Hayes (2000). ""Hookups": Characteristics and correlates of college students' spontaneous and anonymous sexual experiences." Journal of Sex Research **37**(1): 76-88.

Pavignani, E. and J. R. Durao (1999). "Managing external resources in Mozambique: building new aid relationships on shifting sands?" Health Policy Plan **14**(3): 243-53.

Pelto, P. J. and G. H. Pelto (1978). Anthropological research: the structure of inquiry. Cambridge; New York, Cambridge University Press.

Peterson, J. and R. DiClemente (2000). Handbook of HIV prevention. New York, Kluwer/Plenum.

Pfeiffer, J. (2002). "African independent churches in Mozambique: healing the afflictions of inequality." Med Anthropol Q **16**(2): 176-99.

Pfeiffer, J. (2004). "Condom social marketing, Pentecostalism, and structural adjustment in Mozambique: a clash of AIDS prevention messages." Med Anthropol Q **18**(1): 77-103.

Pfeiffer, J., S. Gloyd and L. Ramirez Li (2001). "Intrahousehold resource allocation and child growth in Mozambique: an ethnographic case-control study." Soc Sci Med **53**(1): 83-97.

Pickering, H., M. Okongo, K. Bwanika, B. Nnalusiba and J. Whitworth (1996). "Sexual mixing patterns in Uganda: small-time urban/rural traders." AIDS **10**(5): 533-6.

Pivnick, A. (1993). "HIV infection and the meaning of condoms." Culture, Medicine and Psychiatry **17**: 431-453.

Pool, R. (1997). Anthropological Research on AIDS. HIV prevention and AIDS care in Africa A district level approach, edited by. J. Ng'weshemi, T. Boerma, J. Bennett and D. Schapink. Amsterdam, Netherlands, Royal Tropical Institute.

Poppen, P. J. and C. A. Reisen (1997). "Perception of risk and sexual self-protective behaviour: a methodological critique." AIDS Education and Prevention **9**: 373–390.

Potts, M. (2000). "Thinking about vaginal microbicide testing." Am J Public Health **90**(2): 188-90.

Prata, N., L. Morris, M. Stehr and E. Mazive (2003). Does self-perceived risk of contracting HIV change seuxal behavior and condom use? The case of Mozambican youth. Gaborone, Botwana, International Union for the Scientific Study of Population.

Preston-Whyte, E. and M. Zondi (1992). African teenage pregnancy - whose problem? Questionable Issue: Illegitimacy in South Africa. S. Burman and E. M. Preston-Whyte. Oxford, Oxford University Press: 226-246.

Preston-Whyte, E. M. (1994). "Gender and the lost generation: the dynamics of HIV transmission among black South African teenagers in KwaZulu Natal." Health transition review **4**: 241-55.

Preston-Whyte, E. M. (1999). Reproductive health and the condom dilemma: identifying situation barriers to HIV protection in South Africa. Reistances to Behavioural Change to Reduce HIV/AIDS Infection. J. C. Caldwell. Canberra, Health Transition Centre: 139-55.

Price, N. (2001). "The performance of social marketing in reaching the poor and vulnerable in AIDS control programmes." Health Policy Plan **16**(3): 231-9.

Price, N. and K. Hawkins (2002). "Researching sexual and reproductive behaviour: a peer ethnographic approach." Soc Sci Med **55**(8): 1325-36.

Probst, P. (1999). "Mchape '95, or, The sudden fame of Billy Goodson Chisupe: Healing, social memory and the enigma of the pubic sphere in post-Banda Malawi." Africa 69 **1**: 108-39.

Prochaska, J. and C. Di Clemente (1983). "Stages and processes of self-change of smoking: Toward an integrative model of change." Journal of Consulting Clinical Psychology **5**: 390-395.

Prochaska, J. and W. Velicer (1997). "The transtheoretical model of health behavior change." American Journal of Health Promotion **12**: 38-48.

PSI (2002). National AIDS Prevention Survey (NAPS) of Mozambican Sexual Behaviors and Condom Use - Final Report [INPS: Inquérito Nacional Sobre a Prevenção do SIDA, Comportamento Sexual e Uso do Preservativo - Relatório Final]. Maputo, Population Services International in Mozambique.

PSI (2003). Population Services International in Mozambique: Annual Report. Maputo, MZ, Population Services International.

PSI Mozambique (1997). Communication and Marketing for AIDS Prevention. Maputo, MZ, PSI.

Ramos, R., R. N. Shain and L. Johnson (1995). "Men I mess with don't have anything to do with AIDS: Using ethno-theory to understand sexual risk perception." The Sociological Quarterly **35**: 483-504.

Reiss, I. L. (1967). The Social Context of Pre-Marital Permissiveness. New York, Holt, Rinehart & Winston.

Reiss, I. L. (1986). Journey into sexuality: An exploratory voyage. Englewood Cliffs, NJ, Prentice-Hall.

Renne, E. P. (1993). "Changes in adolescent sexuality and the perception of virginity in a southwestern Nigerian village." Health transition review **3**: 121-133.

Renne, E. P. (1996). "Shifting boundaries of fertility change in Southwestern Nigeria." Health transition review **6**: 169-190.

Richens, J., J. Imrie and A. Copas (2000). "Condoms and seat belts: the parallels and the lessons." Lancet **355**(9201): 400-3.

Rita-Ferreira, A. (1961). Bibliografia Etnologica de Mocambique (das origens a 1954). Lisboa, Junta de Investigacoes do Ultramar.

Rivers, K. and P. Aggleton. (2001). "Adolescent sexuality, gender, and the HIV epidemic." Retrieved [2/19/2002 4:54:03], 2002, from http://www.undp.org/hiv/publications/gender/adolesce.htm (1 of 22) [2/19/2002 4:54:03].

Roffman, R., R. Stephens, L. Curtin, J. Gordon, J. Craver, M. Stern, B. Beadnell and L. Downey (1998). "Relapse prevention as an interventive model for HIV risk reduction in gay and bisexual men." AIDS Education and Prevention **10**(1): 1-18.

Rogers, E. M. (1995 [1983]). Diffusion of Innovations. New York, Free Press.

Rogers, E. M. and F. F. Shoemaker (1971). Communication of Innovations. New York, Free Press.

Rogers, M. F. S., Nathan (1999). "Reducing the Risk of Maternal-Infant Transmission of HIV by Attacking the Virus." New England Journal of Medicine **341**(6): 441.

Rogers, R. W. (1975). "A protection motivation theory of fear appeals and attitude change." The Journal of Psychology **91**: 93-114.

Rogers, R. W. (1983). Cognitive and psychological in fear appeals and attitude change: A revised theory of protection motivation. Social psycho-physiology. J. Cacioppo and R. Petty. New York, Guilford Press.

Rojanapithayakorn, W. and R. Hanenberg (1996). "The 100% condom program in Thailand [editorial]." AIDS **10**(1): 1-7.

Romero-Daza, N. (1994). "Multiple sexual partners, migrant labor, and the makings for an epidemic: Knowledge and beliefs about AIDS among women in highland Lesotho." Human Organization **53**(2): 192-205.

Rose, S. and I. H. Frieze (1989). "Young singles' scripts for a first date." Gender and society **3**: 258-268.

Rose, S. and I. H. Frieze (1993). "Young singles' contemporary dating scripts." Sex Roles **28**: 499-509.

Rosenstock, I. M. (1974). "Historical Origins of the Health Belief Model." Health Education Monographs **2**: 328-335.

Rosenstock, I. M. (1990). The Health Belief Model: Explaining Health Behavior Through Expectancies. Health Behavior and Health Education: Theory, Research and Practice. K. Glanz, F. M. Lewis and B. Rimmer. San Francisco, Jossey-Bass Publishers: 39-62.

Rosenstock, I. M., V. J. Strecher and M. H. Becker (1994). The health belief model and HIV risk behavior change. Preventing AIDS: Theories and methods of behavioral interventions AIDS prevention and mental health. J. L. P. Ralph J. DiClemente, Plenum Press, New York, NY, US: 5-24.

Rosenthal, D., S. Moore and I. Flynn (1991). "Adolescent self-efficacy, self-esteem, and sexual risk-taking." Journal of Community & Applied Social Psychology **1**: 77-88.

Roth, E., E. Fratkin, E. Ngugi and B. Glickman (2001). "Female education, adolescent sexuality and the risk of sexually transmitted infection in Ariaal Rendille culture." CULTURE, HEALTH AND SEXUALITY **3**(1): 35-47.

Runganga, A., M. Pitts and J. McMaster (1992). "The use of herbal and other agents to enhance sexual experience." Social Science and Medicine **35**(8): 1037-1042.

Samucidine, M., J. Barreto, I. Lind, C. Mondlane and S. Bergstrom (1999). "Serological Evidence of Gonorrhoea among Infertile and Fertile Women in Rural Mozambique." African Journal of Reproductive Health **3**(2): 102-105.

Santos, B. and M. J. Arthur (1991). Enquanto os homens tiverem o poder sexual: o comportamento sexual e a expansão do SIDA-DTS. Maputo, MZ, Ministério de Saúde**:** 17.

Santos, B. and M. J. Arthur (1993a). Comportamentos, atitudes e práticas entre os jovens escolares: as DTS, o SIDA, a vida sexual e afectiva. Maputo, MZ, Ministério de Saúde-PNC DTS-SIDA**:** 50.

Santos, B. and M. J. Arthur (1993b). Vida Sexual no Casamento: Práticas Sexuais e a Sexualidade Feminina e Masculina [Sex in Marriage: Sexual practises and the sexuality of women and men]. Maputo, MZ, Ministério de Saúde**:** 71.

Savage, O. M. and T. M. Tchombe (1994). "Anthropological perspectives on sexual behaviour in Africa." Annual Review of Sex Research **5**: 50-72.

Schatzki, T. R. (2000). Introduction: Practice Theory. The practice turn in contemporary theory. K. D. Knorr-Cetina, E. v. Savigny and T. R. Schatzki. London, Routledge**:** 1-14.

Schoepf, B. G. (1993). "AIDS action-research with women in Kinshasa, Zaire. Special Issue: Women, development and health." Social Science & Medicine **37**(11): 1401-1413.

Schoepf, B. G. (1995). Culture, Sex Research and AIDS Prevention in africa. Culture and sexual risk: anthropological perspectives on AIDS. H. T. Brummelhuis and G. H. Herdt. Montreux, Gordon & Breach**:** 29-52.

Scrimshaw, S. C., M. Carballo, L. Ramos and B. A. Blair (1991). "The AIDS Rapid Anthropological Assessment Procedures: a tool for health education planning and evaluation." Health-Educ-Q **18**(1): 111-23.

Seal, D. W., L. I. Wagner-Raphael and A. A. Ehrhardt (2000). "Sex, intimacy, and HIV: An ethnographic study of a Puerto Rican social group in New York City." Journal of Psychology & Human Sexuality **11**(4): 51-92.

Senderowitz, J. (1998). "Involving youth in reproductive health projects." Washington, DC, Pathfinder International, FOCUS on Young Adults, 1998 Sep: 36.

Senderowitz, J. (2000). "A review of program approaches to adolescent reproductive health." Arlington, Virginia, Population Technical Assistance Project [POPTECH], 2000 Jun 1: viii, 63.

Sepulvede, J., H. Fineberg and J. Mann (1992). AIDS prevention through education: a world view. New York, Oxford University Press.

Setel, P. (1995). "AIDS as a Paradox of Manhood and Development in Kilimanjaro, Tanzania." Social Science and Medicine **ms**: 25.

Shepherd, G. (1987). Rank, gender, and homosexuality: Mombasa as a key to understanding sexual options. The Cultural Construction of Sexuality. P. Caplan. London, Tavistock Publications**:** 240-270.

Sherr, K. H., F. Jacqueta, S. O. Gimbel-Sherr, A. Soares, S. Gloyd and M. A. Mercer (2002). Community stigma and HIV/AIDS: A study of knowledge, attitudes and practices among women aged 15-49 in Central Mozambique. Paper presented at the 14th International AIDS Conference, Barcelona, Spain.

Sibthorpe, B. (1992). "The social construction of sexual relationships as a determinant of HIV risk perception and condom use among injection drug users." Medical Anthropology Quarterly **6**(3): 255-70.

Sideris, T. (2003). "War, gender and culture: Mozambican women refugees." Soc Sci Med **56**(4): 713-24.

Siegel, K., F. P. Mesagno, J. Y. Chen and G. Christ (1989). "Factors distinguishing homosexual males practicing risky and safer sex." Soc-Sci-Med **28**(6): 561-9.

Silberschmidt, M. and V. Rasch (2001). "Adolescent girls, illegal abortions and "sugar-daddies" in Dar es Salaam: vulnerable victims and active social agents." Soc Sci Med **52**(12): 1815-26.

Silverman, D. (2000). Doing qualitative research: a practical handbook. London, Sage.

Simon, W. (1996). Postmodern sexualities. London; New York, Routledge.

Simon, W. and J. H. Gagnon (1986). "Sexual scripts: permanence and change." Arch-Sex-Behav **15**(2): 97-120.

Slater, M. D. (1989). "Social influences and cognitive control as predictors of self-efficacy and eating behavior." Cognitive Therapy and Research **13**: 231-45.

Sloane, B. C. and C. G. Zimmer (1993). "The power of peer health education." J-Am-Coll-Health **41**(6): 241-5.

Smith, H. L. (1993a). "On the limited utility of KAP-style survey data in the practical epidemiology of AIDS, with reference to the AIDS epidemic in Chile." Health Transit Rev **3**(1): 1-16.

Smith, H. L. (1993b). "On the limited utility of KAP-style survey data in the practical epidemiology of AIDS, with reference to the AIDS epidemic in Chile." Health transition review **3**(1): 1-16.

Smith, M. U. and H. P. Katner (1995). "Quasi-experimental evaluation of three AIDS prevention activities for maintaining knowledge, improving attitudes, and changing risk behaviors of high school seniors." AIDS-Educ-Prev **7**(5): 391-402.

Snell, W. E., T. D. Fisher and T. Schuh (1992). "Reliability and Validity of the Sexuality Scale - a Measure of Sexual-Esteem, Sexual-Depression, and Sexual-Preoccupation." Journal of Sex Research **29**(2): 261-273.

Speizer, I. S., R. J. Magnani and C. E. Colvin (2003). "The effectiveness of adolescent reproductive health interventions in developing countries: a review of the evidence." J Adolesc Health **33**(5): 324-48.

Spradley, J. P. (1979). The ethnographic interview. New York; London, Holt, Rinehart and Winston.

Sprecher, S. (1998). "Social exchange theories and sexuality." Journal of Sex Research **35**(1): 32-43.

Stadler, J. (2003). "Rumor, gossip and blame: implications for HIV/AIDS prevention in the South African lowveld." AIDS Educ Prev **15**(4): 357-68.

Stallworthy, G., A. S. Karlyn and C. Davis (2000). A Social Marketing Behaviour Change Framework. The Inhaca Island Behaviour Change Workshop and Retreat, Inhaca Island, Mozambique, Population Services International (PSI) in Mozambique.

Strauss, A. and J. Corbin (1998). Grounded theory: An overview. Strategies of qualitative inquiry. N. K. Denzin and Y. S. Lincoln. Thousand Oaks, Calif., Sage Publications: xxii, 346 p.

Strecher, V. J., B. M. DeVellis, M. H. Becker and I. M. Rosenstock (1986). "The role of self-efficacy in achieving health behavior change." Health-Educ-Q **13**(1): 73-92.

Swart-Kruger, J. and L. M. Richter (1997). "AIDS-related knowledge, attitudes and behaviour among South African street youth: reflections on power, sexuality and the autonomous self." Soc Sci Med **45**(6): 957-66.

Sweet, J. H. (1996). "Male Homosexuality and Spiritism in the African Diaspora: The Legacies of a Link." Journal of the History of Sexuality **7**(1): 184-202.

Tarantola, D. J., Hannum, Boland and e. al. (1997). Policies and Programs on Sexually Transmitted Infections: The gap between intent and action. Geneva, CH & Boston, MA, The World Health Organization & The François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health Boston.

Tarp, F., K. Simler, C. Matusse, R. Heltberg and G. Dava (2002). "The robustness of poverty profiles reconsidered." Economic Development and Cultural Change **51**(1): 77-108.

Tattevin, P., P. Renault, V. Joly, R. Bastos, E. Coelho, C. Adda, A. Ebel and P. Yeni (2002). "Treatment of Latent Syphilis in HIV-infected Patients with 10 d of Benzylpenicillin G Benethamine: A Prospective Study in Maputo, Mozambique." Scand J Infect Dis **34**: 257-261.

Taylor, C. C. (1990). "Condom and Cosmology: The "Fractal" Person and Sexual Risk in Rwanda." Social Science and Medicine **31**(9): 1023-1028.

Taylor, S. J. and R. Bogdan (1984). Introduction to qualitative research methods: the search for meanings. New York; Chichester, Wiley.

Tewksbury, R. (1996). "Cruising for sex in public places: the structure and language of men's hidden, erotic worlds." Deviant Behavior **17**: 1-19.

The Voluntary HIV-1 Counseling and Testing Efficacy Study Group (2000). "Efficacy of voluntary HIV-1 counselling and testing in individuals and couples in Kenya, Tanzania, and Trinidad: a randomised trial." Lancet **356**(9224): 103-12.

Tomkins, S. S. (1978). "Script theory: differential magnification of affects." Nebr Symp Motiv **26**: 201-36.

Trochim, W. M. (2002). "The Research Methods Knowledge Base." 2nd Edition. Retrieved January 14, 2004, from http://trochim.human.cornell.edu/kb/index.htm.

Trotter, R. T. and J. M. Potter (1993). "Pile sorts, a cognitive anthropological model of drug and AIDS risks for Navajo teenagers: Assessment of a new evaluation tool." Drugs & Society **7**(3-4): 23-39.

Trotter, R. T. and J. J. Schensul (1998). Methods in Applied Anthropology. Handbook of Methods in Cultural Anthropology. H. R. Bernard. Walnut Creek, CA, Altamira Press (Sage)**:** 691-736.

Ulin, P. (1992). "African women and AIDS: negotiating behavioral change." Social Science and Medicine **34**(1): 63-73.

UNAIDS. (1998). "UNAIDS Epidemiological Fact Sheet: AIDS in Africa." Retrieved December, 1998, from http://www.unaids.org/.

UNAIDS. (1998b). "UNAIDS Epidemiological Fact Sheet: Mozambique." Retrieved July, 1998, from http://www.unaids.org/.

UNAIDS (1999a). AIDS Epidemic Update: December 1999. Geneva, UNAIDS.

UNAIDS (1999b). Sex and youth: contextual factors affecting risk for HIV/AIDS. A comparative analysis of multi-site studies in developing countries. Geneva, The Joint United Nations Programme on HIV/AIDS**:** 145.

UNAIDS (2002a). Report on fhte Global HIV/AIDS Epidemic. Geneva, The Joint United Nations Programme on HIV/AIDS.

UNAIDS (2002b). UNAIDS Epidemiological Fact Sheet: Mozambique 2002 Update. Geneva, United Nations Joint Programme on HIV/AIDS.

UNDP. (2000). "Mozambique National Human Development Report." Retrieved 10/24/2003 11:06:22 AM, 2003, from http://www.sardc.net/HDev/MHDR2000/Eng/Chapter3/15.html.

UNDP (2003). Human development report 2003. Millennium Development Goals: a compact among nations to end human poverty. New York, New York, Oxford University Press.

UNFPA (2000). State of the World Population 2000: Lives together, worlds apart. New York, United Nations Population Fund (UNFPA). 76.

United Nations (2004). Map No. 3706, Rev. 4 (Jan). Washington, DC, Department of Peacekeeping Operations, Cartographic Section.

Upchurch, D. M., C. S. Weisman, M. Shepherd, R. Brookmeyer, R. Fox, D. D. Celentano, L. Colletta and E. W. Hook, 3rd (1991). "Interpartner reliability of reporting of recent sexual behaviors." Am J Epidemiol **134**(10): 1159-66.

USAID. (2003, March). "Country Health Statistical Report – Mozambique." Retrieved March, 2003, from http://www.usaid.gov/pop_health/home/Countries/africa/mozambique.pdf.

Valdiserri, R. O., V. C. Arena, D. Proctor and F. A. Bonati (1989). "The relationship between women's attitudes about condoms and their use: implications for condom promotion programs." Am-J-Public-Health **79**(4): 499-501.

Valente, T. W., P. R. Poppe and A. P. Merritt (1996). "Mass-media-generated interpersonal communication as sources of information about family planning." Journal of Health and Communication **1**(6): 247-265.

van Campenhoudt, L. (1997). Operationalizing Theories for Further Research. Sexual Interactions and HIV Risk: New Conceptual Perspectives in European Research. L. van Campenhoudt, M. Cohen, G. Guizzardi and D. Hausser. London, Taylor & Francis**:** 181-188.

van Campenhoudt, L. and M. Cohen (1997). Interaction and Risk-related Behaviour: Theoretical and Heuristic Landmarks. Sexual Interactions and HIV Risk: New Conceptual Perspectives in European Research. L. van Campenhoudt, M. Cohen, G. Guizzardi and D. Hausser. London, Taylor & Francis**:** 59-74.

van Campenhoudt, L., M. Cohen, G. Guizzardi and D. Hausser, Eds. (1997). Sexual Interactions and HIV Risk: New Conceptual Perspectives in European Research. Social Aspects of AIDS. London, Taylor & Francis.

van der Pligt, J., W. Otten, R. Richard and F. van der Velde (1993). Perceived risk of AIDS: Unrealistic optimism and self-protective action. The social psychology of HIV infection. G. D. R. John B. Pryor, Lawrence Erlbaum Associates, Inc, Hillsdale, NJ, US**:** 39-58.

Van Rossem, R. and D. Meekers (2000). "An evaluation of the effectiveness of targeted social marketing to promote adolescent and young adult reproductive health in Cameroon." AIDS Educ Prev **12**(5): 383-404.

Vance, C. S. (1991). "Anthropology Rediscovers Sexuality: A Theoretical Comment." Social Science and Medicine **33**(8): 875-884.

Vandemoortele, J. and E. Delamonica (2000). "The "education vaccine" against HIV." Current Issues in Comparative Education **10**(1): 10.

Vanderford, M. L., D. H. Smith and W. S. Harris (1992). "Value identification in narrative discourse: Evaluation of an HIV education demonstration project." Journal of Applied Communication Research **20**(2): 123-160.

VanLandingham, M., J. Knodel, C. Saengtienchai and A. Pramualratana (1994). "Aren't sexual issues supposed to be sensitive?" Health transition review **4**(1): 85-90.

Varga, C. A. (1997a). "The condom conundrum: barriers to condom use among commercial sex workers in Durban, South Africa." Afr J Reprod Health **1**(1): 74-88.

Varga, C. A. (1997b). "Sexual decision-making and negotiation in the midst of AIDS: youth in KwaZulu Natal, South Africa." Health transition review **7**(Supplement 3): 45-67.

Varga, C. A. (1999). South African young people's sexual dynamics: implications for behavioural responses to HIV/AIDS. Reistances to Behavioural Change to Reduce HIV/AIDS Infection. J. C. Caldwell. Canberra, Health Transition Centre**:** 13-34.

Vasconcelos, A., V. Garcia, M. C. Mendonca, M. Pacheco, M. G. Pires, C. Tassitano and C. Garcia (1997). "Sexuality and AIDS prevention among adolescents in Recife, Brazil." Washington, DC, International Center for Research on Women [ICRW], Women and AIDS Research Program **7**.

Vaz, R. G., S. Gloyd, E. Folgosa and J. Kreiss (1995). "Syphilis and HIV infection among prisoners in Maputo, Mozambique." International Journal of Std and Aids **6**(1): 42-6.

Vaz, R. G., S. Gloyd and R. Trindade (1996). "The effects of peer education on STD and AIDS knowledge among prisoners in Mozambique." International Journal of Std and Aids **7**(1): 51-4.

Vuylsteke, B., R. Bastos, J. Barreto, T. Crucitti, E. Folgosa, J. Mondlane, T. Dusauchoit, P. Piot and M. Laga (1993a). "High prevalence of sexually transmitted diseases in a rural area in Mozambique." Sex Transm Infect **69**(6): 427-430.

Vuylsteke, B., R. Bastos, J. Barreto, T. Crucitti, E. Folgosa, J. Mondlane, T. Dusauchoit, P. Piot and M. Laga (1993b). "High prevalence of sexually transmitted diseases in a rural area in Mozambique." Genitourinary medicine **69**(6): 427-430.

Walden, V. M., K. Mwangulube and P. Makhumula-Nkhoma (1999). "Measuring the impact of a behaviour change intervention for commercial sex workers and their potential clients in Malawi." Health Educ Res **14**(4): 545-54.

Wallman, S. (2000). "Risk, STD and HIV infection in Kampala." Health, Risk & Society **2**(2): 189-203.

Walt, G. and A. Melamed (1983). Mozambique: towards a people's health service. London, Zed Press.

Walter, H. J., R. D. Vaughan, M. M. Gladis, D. F. Ragin, S. Kasen and A. T. Cohall (1992). "Factors associated with AIDS risk behaviors among high school students in an AIDS epicenter." Am J Public Health **82**(4): 528-32.

Warren, M. and A. Philpott (2003). "Expanding safer sex options: introducing the female condom into national programmes." Reprod Health Matters **11**(21): 130-9.

Weeks, J. (1987). Questions of identity. The Cultural Construction of Sexuality. P. Caplan. London, Tavistock Publications: 31-51.

Weeks, J. (1995). History, Desire and Identities. Conceiving Sexuality: Approaches to Sex Research in a Postmodern World. R. Parker and J. Gagnon. New York, Routledge: 34-50.

Weis, D. L. (1998). "Conclusion: The state of sexual theory." Journal of Sex Research **35**(1): 100-114.

Weiss, E., D. Whelan and G. Rao Gupta (2000). "Gender, sexuality and HIV: making a difference in the lives of young women in developing countries." Sexual and Relationship Therapy **15**(3): 233-245.

Weiss, M. (2001). "Cultural epidemiology: an introduction and overview." Antrhopology & Medicine **8**(1): 5-29.

Wellings, K., P. Branigan and K. Mitchell (2000). "Discomfort, discord and discontinuity as data: using focus groups to research sensitive topics." Culture, Health & Sexuality **2**(3): 255-267.

Wellings, K. and B. Field (1997). Stopping AIDS: AIDS/HIV Public education and the mass media in Europe. Harlow, Longman.

Wellings, K. and W. Macdowall (2000). Evaluating mass media approaches. Evaluating health promotion: practice and methods. M. Thorogood and Y. Coombes. New York; Oxford, Oxford University Press: 174p.

Wellings, K., J. Wadsworth, A. M. Johnson, J. Field, L. Whitaker and B. Field (1995). "Provision of sex education and early sexual experience: the relation examined." Bmj **311**(7002): 417-20.

Westoff, C. F. (1988). "Is the KAP-gap real?" Population and Development Review **14**(2): 225-32.

WHO (1992). A study of the sexual experience of young people in eleven African countries: the narrative research method. Geneva, CH, World Health Organization [WHO]. Division of Family Health. Adolescent Health Programme; World Assembly of Youth: [3], 47 p.

WHO (1993a). Adolescent Sexual Behaviour and Reproductive Health: From Research to Action: The Narrative Research Method. Geneva, WHO, Adolescent Health Programme, Division of Family Health.

WHO (1993b). The narrative research method. Studying behaviour patterns of young people - by young people. A guide to its use. Geneva, Switzerland, World Health Organization [WHO]. Division of Family Health. Adolescent Health Programme: 38.

Wilson, D. (2000). Corridors of Hope - Mozambique. Maputo, Family Health International.

Wingood, G. M. and R. J. DiClemente (1996). "HIV sexual risk reduction interventions for women: a review." Am J Prev Med **12**(3): 209-17.

Wingood, G. M., R. J. DiClemente, K. Harrington, S. Davies, E. W. Hook, 3rd and M. K. Oh (2001). "Exposure to X-rated movies and adolescents' sexual and contraceptive-related attitudes and behaviors." Pediatrics **107**(5): 1116-9.

Witte, K. and K. Morrison (1995). "Using scare tactics to promote safer sex among juvenile detention and high school youth." Journal of Applied Communication Research **23**(2): 128-142.

Wojcicki, J. and J. Malala (2001). "Condom use, power and HIV/AIDS risk: sex-workers bargain for survival in Hillbrow/Joubert Park/ Berea, Johannesburg." Social Science & Medicine **53**: 99–121.

Wolff, B., J. Knodel and W. Sittitrai (1991). "Focus groups and surveys as complementary research methods: examples from a study of the consequences of family size in Thailand." Ann Arbor, MI, Univ of Michigan, Population Studies Center: 91-213.

Wood, K., F. Maforah and R. Jewkes (1998). ""He forced me to love him": putting violence on adolescent sexual health agendas." Soc Sci Med **47**(2): 233-42.

World Bank (2000a). Action Aid: Stepping Stones Program. Education and HIV/AIDS: A Sourcebook of HIV/AIDS Prevention Programs. The World Bank. Washington, DC, Education Advisory Service, The World Bank: 27-48.

World Bank (2000b). UNFPA and Pathfinder International: Geração Biz, Youth-Friendly Health Clinics. Education and HIV/AIDS: A Sourcebook of HIV/AIDS Prevention Programs. The World Bank. Washington, DC, Education Advisory Service, The World Bank: 49-72.

World Bank. (2001). "Development Indicators CD-Rom."

World Bank. (2002). "Development Indicators CD-Rom."

Worth, D. (1989). "Sexual decision-making and AIDS: why condom promotion among vulnerable women is likely to fail." Studies in Family Planning **20**(6 Pt 1): 297-307.

Wortley, P. M., S. Y. Chu, T. Diaz, J. W. Ward, B. Doyle, A. J. Davidson, P. J. Checko, M. Herr, L. Conti, S. A. Fann, F. Sorvillo, E. Mokotoff, A. Levy, P. Hermann and E. Norris-Walczak (1995). "HIV testing patterns: where, why, and when were persons with AIDS tested for HIV?" AIDS **9**: 487-492.

Wright, T. M. and S. P. Reise (1997). "Personality and unrestricted sexual behavior: Correlations of sociosexuality in Caucasian and Asian college students." Journal of Research in Personality **31**: 166-192.

Young, L. and N. Ansell (2003). "Young AIDS migrants in Southern Africa: Policy implications for empowering children." AIDS Care **15**(3): 337-345.

Zaba, B., T. Boerma and R. White (2000). "Monitoring the AIDS epidemic using HIV prevalence data among young women attending antenatal clinics: prospects and problems." AIDS **14**(11): 1633-45.

Zabin, L. S. and K. Kiragu (1998). "The health consequences of adolescent sexual and fertility behavior in sub-Saharan Africa." Stud Fam Plann **29**(2): 210-32.

# 11 ANNEXES

## 11.1 Summary of interviews

| *TYPE* | *ID#* | *AGE* | *SEX* | *CLASS* | *SCHOOL* | *ACTIVE* |
|---|---|---|---|---|---|---|
| SSI | 101 | 19 | ♂ | 12th | In | Yes |
| SSI | 102 | 18 | ♂ | 10th | In | Yes |
| SSI | 103 | 17 | ♂ | 8th | In | Yes |
| SSI | 104 | 17 | ♂ | 7th | In | No |
| SSI | 105 | 27 | ♂ | 11th | Out | Yes |
| SSI | 106 | 22 | ♂ | 11th | Out | No |
| SSI | 107 | 20 | ♂ | 11th | Out | Yes |
| SSI | 108 | 22 | ♂ | 12th | Out | Yes |
| SSI | 109 | 22 | ♂ | 12th | Out | Yes |
| SSI | 110 | 24 | ♂ | 6th | Out | Yes |
| SSI | 111 | 24 | ♂ | 12th | Out | Yes |
| SSI | 112 | 23 | ♂ | 12th | Out | Yes |
| SSI | 113 | 24 | ♂ | 10th | Out | Yes |
| SSI | 114 | 21 | ♂ | th | Out | Yes |
| SSI | 115 | 21 | ♂ | 12th | Out | Yes |
| SSI | 116 | 21 | ♂ | 7th | Out | Yes |
| SSI | 117 | 25 | ♂ | 5th | Out | Yes |
| SSI | 201 | 16 | ♀ | 8th | In | Yes |
| SSI | 202 | 16 | ♀ | 10th | In | Yes |
| SSI | 203 | 16 | ♀ | 7th | In | No |
| SSI | 204 | 20 | ♀ | 10th | In | Yes |
| SSI | 205 | 21 | ♀ | 7th | In | Yes |
| SSI | 206 | 26 | ♀ | 12th | In | Yes |
| SSI | 207 | 21 | ♀ | 11th | In | Yes |
| SSI | 208 | 22 | ♀ | 3th | In | Yes |
| SSI | 209 | 22 | ♀ | 8th | Out | Yes |
| SSI | 210 | 20 | ♀ | 7th | Out | Yes |
| SSI | 211 | 18 | ♀ | 9th | Out | Yes |
| SSI | 212 | 19 | ♀ | 12th | Out | Yes |
| SSI | 213 | 16 | ♀ | 5th | Out | No |
| SSI | 214 | 21 | ♀ | 12th | Out | Yes |
| SSI | 215 | 24 | ♀ | 6th | Out | Yes |
| SSI | 216 | 23 | ♀ | 3th | Out | Yes |

| *TYPE* | *ID#* | *AGE* | *SEX* | *CLASS* | *SCHOOL* | *ACTIVE* |
|---|---|---|---|---|---|---|
| SSI | 217 | 20 | ♀ | 12th | Out | Yes |
| SSI | 218 | 21 | ♀ | 6th | Out | Yes |
| SSI | 301 | 18 | ♀ | 8th | In | No |
| SSI | 302 | 16 | ♀ | 9th | In | No |
| SSI | 303 | 16 | ♀ | 6th | In | No |
| SSI | 304 | 21 | ♀ | 7th | In | Yes |
| SSI | 305 | 23 | ♀ | 13th | In | Yes |
| SSI | 306 | 21 | ♀ | 7th | In | Yes |
| SSI | 307 | 20 | ♀ | 10th | Out | Yes |
| SSI | 308 | 23 | ♀ | 11th | In | Yes |
| SSI | 309 | 27 | ♀ | 8th | Out | Yes |
| SSI | 310 | 19 | ♀ | 3th | Out | Yes |
| SSI | 311 | 20 | ♀ | 7th | Out | Yes |
| SSI | 312 | 21 | ♀ | 11th | Out | Yes |
| SSI | 313 | 21 | ♀ | 9th | Out | Yes |
| SSI | 314 | 19 | ♀ | 3th | Out | Yes |
| SSI | 315 | 20 | ♀ | 5th | Out | Yes |
| SSI | 316 | 17 | ♀ | 5th | Out | Yes |
| SSI | 317 | 18 | ♀ | 5th | Out | Yes |
| SSI | 318 | 23 | ♀ | 8th | Out | Yes |
| SSI | 401 | | ♂ | 7th | In | Yes |
| SSI | 402 | 18 | ♂ | 8th | In | Yes |
| SSI | 403 | 20 | ♂ | 7th | In | Yes |
| SSI | 404 | 18 | ♂ | 8th | In | Yes |
| SSI | 405 | 18 | ♂ | 7th | In | Yes |
| SSI | 406 | 20 | ♂ | 7th | In | Yes |
| SSI | 407 | 26 | ♂ | 13th | In | Yes |
| SSI | 408 | 20 | ♂ | 10th | In | Yes |
| SSI | 409 | 25 | ♂ | 3th | In | Yes |
| SSI | 410 | 21 | ♂ | 10th | In | Yes |
| SSI | 411 | 23 | ♂ | 6th | Out | Yes |
| SSI | 412 | 27 | ♂ | 13th | Out | Yes |
| SSI | 413 | 23 | ♂ | 7th | Out | Yes |
| SSI | 414 | 19 | ♂ | 8th | In | Yes |
| SSI | 415 | 22 | ♂ | 9th | Out | Yes |
| SSI | 416 | 18 | ♂ | 8th | In | Yes |

| *TYPE* | *ID#* | *AGE* | *SEX* | *CLASS* | *SCHOOL* | *ACTIVE* |
|---|---|---|---|---|---|---|
| SSI | 417 | 20 | ♂ | 6th | Out | Yes |
| SSI | 418 | 17 | ♂ | 6th | Out | Yes |
| SSI | 501 | 28 | ♀ | 13th | In | Yes |
| SSI | 502 | 20 | ♀ | 11th | In | No |
| SSI | 601 | 20 | ♂ | 11th | In | Yes |
| FG | 702 | 16 | ♀ | 9th | Out | No |
| FG | 704 | 16.5 | ♀ | 9th | Out | Yes |
| FG | 705 | 21 | ♀ | 11th | Out | Yes |
| FG | 706 | 21 | ♀ | 10th | Out | Yes |
| FG | 707 | 18 | ♀ | 10th | Out | Yes |
| FG | 708 | 18 | ♀ | 7th | Out | Yes |
| FG | 709 | 21 | ♀ | 7th | Out | Yes |
| FG | 710 | 25 | ♀ | 4th | Out | Yes |
| FG | 711 | 19 | ♀ | 7th | Out | Yes |
| FG | 712 | 15 | ♂ | 9th | Out | Yes |
| FG | 713 | 18 | ♀ | 10th | Out | Yes |
| FG | 714 | 19 | ♂ | 10th | Out | Yes |
| FG | 715 | 22 | ♀ | 9th | Out | Yes |
| FG | 801 | 21 | ♂ | 12th | Out | Yes |
| FG | 802 | 21 | ♂ | 12th | Out | Yes |
| FG | 803 | 19 | ♂ | 9th | Out | Yes |
| FG | 804 | 21 | ♂ | 10th | Out | Yes |
| FG | 805 | 25 | ♂ | 7th | Out | Yes |
| FG | 806 | 19 | ♂ | 6th | Out | Yes |
| FG | 807 | 19 | ♂ | 8th | Out | Yes |
| FG | 901 | 21 | ♀ | 10th | Out | Yes |
| FG | 902 | 21 | ♂♀ | 12th | Out | Yes |

## 11.2 Mozambique: Socio-demographic indicators

| Indicator | Value | Year | Source |
|---|---|---|---|
| Total Population | 19,111,633 | 2004 | BUCEN-IDB-2004 |
| Population Growth Rate (%) | 1.6 | 2004 | BUCEN-IDB-2004 |
| Percent Urban (%) | 34.3 | 2002 | World Bank/WDI-2004 |
| Women, 15-19 | 956,481 | 2004 | BUCEN-IDB-2004 |
| Women, 15-49 | 4,566,240 | 2004 | BUCEN-IDB-2004 |
| Life Expectancy at Birth | 40.9 | 2004 | BUCEN-IDB-2004 |
| Crude Birth Rate (per 1,000) | 36.5 | 2004 | BUCEN-IDB-2004 |
| Crude Death Rate (per 1,000) | 20.6 | 2004 | BUCEN-IDB-2004 |
| GNI per Capita (PPP in USD) | 990 | 2002 | World Bank/WDI-2004 |
| Health Expenditure as Percentage of GDP (%) | 5.9 | 2001 | World Bank/WDI-2004 |
| Physicians per 1,000 People | 0.02 | 1985 | World Bank/WDI-2004 |
| Adult Literacy Rate (%) | 46.5 | 2002 | World Bank/WDI-2004 |
| Adult Literacy Rate, Female (%) | 31.4 | 2002 | World Bank/WDI-2004 |
| Adult Literacy Rate, Male (%) | 62.3 | 2002 | World Bank/WDI-2004 |
| Gross Enrollment Rate - Primary School (%) | 91.5 | 2000 | UNESCO-2003/4 |
| Gender Parity Index - Net Enrollment Rate | 0.85 | 2000 | UNESCO-2003/4 |
| Access to an Improved Water Source (Rural) (%) | 41 | 2000 | World Bank/WDI-2004 |
| Access to an Improved Water Source (Urban) (%) | 81 | 2000 | World Bank/WDI-2004 |
| Access to Improved Sanitation Facilities (Rural) (%) | 26 | 2000 | World Bank/WDI-2004 |
| Access to Improved Sanitation Facilities (Urban) (%) | 68 | 2000 | World Bank/WDI-2004 |
| Total Fertility Rate (DHS) | 5.6 | 2003 | Moz DHS-2003 |
| Contraceptive Prevalence Rate, Modern Methods, All Women (%) | 18.4 | 2003 | Moz DHS-2003 |
| Contraceptive Prevalence Rate, Modern Methods, Married Women (%) | 16.4 | 2003 | Moz DHS-2003 |
| Median Age of Sexual Debut Among Women, Ages 25-49 | 16.1 | 2003 | Moz DHS-2003 |
| Mean Ideal Family Size (Women) | 5.3 | 2003 | Moz DHS-2003 |

| Indicator | Value | Year | Source |
|---|---|---|---|
| Women 20-24 Who Gave Birth Before Age 20 (%) | 67.8 | 2003 | Moz DHS-2003 |
| Maternal Mortality Ratio (WHO/Hill) (per 1,000) | 1,000 | 2000 | WHO/Hill-2004 |
| Antenatal Care (at least 1 visit) (%) | 84.2 | 2003 | Moz DHS-2003 |
| Number of Live Births | 678,351 | 2004 | BUCEN-IDB-2004 |
| TB Estimated Number of Cases | 79,144 | 2000 | WHO 2002 |
| TB Case Detection Rate (%) | 40 | 2000 | WHO 2002 |
| TB (DOTS) Treatment Success Rate (%) | 71 | 1999 | WHO 2002 |
| Malaria (reported cases) | 1,360,686 | 1999 | WHO/RBM 2003 |
| ARI Treatment - Children Under 5 (% ) | 51.4 | 2003 | Moz DHS-2003 |
| ORT Use Rate (ORS, RHS, or Increased Fluids) (% ) | 70.2 | 2003 | Moz DHS-2003 |
| Infant Mortality Rate (DHS) (per 1,000 live births ) | 125 | 2003 | Moz DHS-2003 |
| Under-5 Mortality Rate (DHS) (per 1,000 live births ) | 180 | 2003 | Moz DHS-2003 |
| Exclusive Breastfeeding (under 4 mos.) (% ) | 39.5 | 2003 | Moz DHS-2003 |
| Stunted (height-for-age) (% ) | 41 | 2003 | Moz DHS-2003 |
| Underweight (weight-for-age) (% ) | 23.7 | 2003 | Moz DHS-2003 |
| Wasted (weight-for-height) (% ) | 4 | 2003 | Moz DHS-2003 |
| Children 12-23 months who received DPT3 at any time (% ) | 71.4 | 2003 | Moz DHS-2003 |
| Children 12-23 months who received all vaccines (BCG, polio, DPT, measles) (%) | 63.3 | 2003 | Moz DHS-2003 |
| Women receiving at least 1 Tetanus Toxoid Vaccination (% ) | 77.8 | 2003 | Moz DHS-2003 |

## 11.3 Implicit assumptions

| FACTOR | ACTIVITY | IMPLICIT THEORY | DESIRED OUTCOME |
|---|---|---|---|
| Personal Risk Perception<br><br>Awareness of HIV / AIDS and STIs<br><br>Knowledge of prevention methods<br><br>Personal perception of being at risk | Mass media[1]<br>IPC[2]<br>Print [3]<br>Events† | Youth lack accurate information<br><br>Youth irresponsible, hedonistic, short term focussed | Aware of HIV / AIDS & STIs<br><br>Know all ways of preventing getting HIV / AIDS<br>Someone with HIV / AIDS can look healthy and still transmit the virus<br>Know symptoms of STIs in self and partner(s)<br>HIV cannot be passed by casual contact<br>HIV passed principally by sexual transmission<br><br>AIDS is a real, and serious problem to self and community now and in the future<br>No cure for AIDS exists<br>Know someone with HIV or died of AIDS<br>Having sex with many partners without the use of condoms is a an important source of risk<br>Changed sexual behaviour to avoid getting HIV / AIDS |
| Solution Efficacy | Mass media[1]<br>IPC[2]<br>Print [3]<br>Events† | The resources provided to young people mitigate the risks they perceive | Condoms prevent HIV / AIDS, STIs, pregnancy<br>Condoms erotic |
| Enabling Environment<br><br>Prevailing climate of opinion<br><br>Social Network | Generic Mass Media<br><br>IPC - fogo cruzado Module 3; | Youth will face the risk of HIV / AIDS if society as a whole accepts responsibility for the disease | Larger structural factors, such as social expectations, inhibit<br><br>Getting AIDS is not shameful<br>A person can lead a normal life if HIV+<br>No stigma associated with condom use<br>Break the silence about STIs and HIV / AIDS<br>improved policy environment – political will and prioritisation of AIDS as an urgent health, social, economic and political issue |

| FACTOR | ACTIVITY | IMPLICIT THEORY | DESIRED OUTCOME |
|---|---|---|---|
| | | | individual health behaviour for youth |
| | | If only youth could talk to their partners, parents and significant others about sex and condoms, they would change their risky behaviour | IPC between partners and immediate social environment necessary for youth to adopt behaviour change<br><br>The potential for reciprocity in trust, confidence, and personal benefit guides individual norms and capacity to carry out behaviour change‡<br><br>Partner communication about issues of health, sexuality, marriage, love<br>Community communication about prevention, impact, human rights, care and support<br>Norms of behaviour – sexarche, condom use, unwanted pregnancy, sexual adventurism<br>Regularly speak about issues of health, sexuality, marriage or love with significant others (family, friends, neighbours, colleagues, acquaintances etc.)<br>Significant others approve of and encourage condom use<br>Feel that using condoms is the right thing to do<br>Actively promote condom use among significant others (advocacy), i.e. give a friend a condom |
| Accessibility<br><br>Affordability<br>Availability | Commercial distribution<br>POS | Physical, economic, and social barriers impede youth access to condoms | Condoms are available:<br>any time of the day or night<br>across a wide variety of outlets<br>close by – within a 5 minute walk<br>at a low price |
| Self-Efficacy – Skills and intent to do something about preventing getting HIV / AIDS | IPC-<br><br>fogo cruzado4<br><br>Theatre | Youth lack the skills / ability to negotiate 'safe sex'<br><br>Gender power relationships dictate sexual practice | Confidence and ability to:<br>- talk about sex with your regular / non-regular partner(s)<br>- obtain condoms via public source (free) or private / commercial (purchase)<br>- apply a condom to self or partner<br>- refuse sex with partner if s/he did not use a condom |

| FACTOR | ACTIVITY | IMPLICIT THEORY | DESIRED OUTCOME |
|---|---|---|---|
| | | | - refuse casual sex<br>- convince partner to use a condom in next sexual encounter (initiate condom use)<br>- talk to partner about past sexual histories<br>- notify partner if diagnosed with a case of STI<br>- remain faithful to partner while on an extended trip or long absence<br>- give partner a condoms just before an extended trip or long absence |
| Brand Attributes<br><br>Brand Equity<br>Lifestyle Brand Appeal | Branded mass media<br><br>IPC<br><br>POS | Brand identification is a positive factor in motivating youth to adopt changes in identity and thus lifestyles | Condoms protect against HIV, STIs, and unwanted pregnancy<br>Condoms don't break<br>Condoms are sexy, they give pleasure and confidence during sex for both partners<br>Condoms are sold for people like me<br>I like the way they advertise condoms, it's something serious but at the same time funny, sexy and necessary<br>I have my own brand of condoms. |
| Outcome Behaviours | Abstinence<br>Be faithful to one partner<br>Consistent condom use<br>Delay sexarche<br>Seek treatment for STIs<br>Get tested regularly<br>Prevent MTCT | | |

[1] Mass Media: Radio (jingles, telenovela dramas, call-ins); TV (generic PSAs, documentaries, telenovelas); Video presentations – Silent Epidemic

[2] IPC – Interpersonal Communications: Peer education activities – fogo cruzado peer education debate; street theatre

[3] Pamphlets, posters, newspaper articles, comic strips, picture books

[4] Public Events: World AIDS Day; Sarau *Jeito* parties; music concerts

[5] *Fogo cruzado*, modules 2,3

[‡] see Fukuyama's definition of social capital (http://www.imf.org/external/pubs/ft/seminar/1999/reforms/fukuyama.htm#I)

POS – point of sale promotional materials

## 11.4 Timeline of research activity

| Week 1 | Week 2 |
|---|---|
| 1. Initial contacts with PSI and NACP staff Contact list:<br>1.1. PSI MAP, Communications and Directors<br>1.2. MoH / NACP<br>1.3. NGOs (SCF-UK, SCF-US, CARE, Oxfam, Med. Monde, AMODEFA, Pathfinder)<br>1.4. INE / Census, DNE<br>2. Develop implementation and logistics plans<br>2.1. Make contacts for KIs<br>2.2. Review selection and sampling criteria<br>2.3. Send CAs to make contacts<br>2.4. Review candidates<br>2.5. Finalise contacts<br>2.6. Send invitations to participate with schedule<br>3. Translate screening questionnaires and interview guides for KIs and focus groups<br>3.1.1. Review questionnaire protocols<br>3.1.2. Translate and back translate<br>3.1.3. Layout and print | 4. Develop training protocol and workshop<br>4.1.1. Define training objectives<br>4.1.2. Define training methodology<br>4.1.3. Develop training materials<br>4.1.3.1. Theory Overview<br>4.1.3.2. Group / individual interview techniques<br>4.1.3.3. Participatory / Forum Theatre techniques<br>4.1.3.4. Field practice of moderator guides<br>4.1.3.5. Coding and debriefing process<br>4.1.4. Identify resources necessary for training (use Benjamin and João Chauque for training)<br>4.1.5. Develop materials for training<br>5. Pre-test questionnaires and guides<br>5.1. Screen KI candidates<br>5.2. Develop data entry protocol and coding scheme<br>6. Recruit data entry staff |
| **Week 3** | **Week 4** |
| 7. Finalise training protocol<br>8. Develop FG & SSI sampling plan<br>8.1. Identify sampling frame per target group<br>8.2. Select sample | 9. Finalise all moderator guides<br>10. KI Interviews Round 1 (short)<br>11. Finalise logistical arrangements for training and interview schedules |
| **Week 5** | **Week 6** |
| 12. Training seminar<br>12.1. Theory<br>12.2. Interview techniques<br>12.3. Field practice<br>12.4. Coding and debriefing process | 13. KI (round 2)<br>14. FG discussions (3 per week)<br>15. SSI (2 / day x 5 days)<br>16. Daily debrief, data entry, coding |
| **Week 7** | **Week 8** |
| 17. FG discussions (3 per week)<br>18. SSI (2 / day x 5 days)<br>19. Daily debrief, data entry, coding | 20. Reflection week:<br>20.1. Debriefing<br>20.2. Review transcripts<br>20.3. Secondary coding<br>20.4. Revise moderator guides and data collection strategy |
| **Week 9** | **Week 10** |
| 21. KI (round 3)<br>22. FG discussions (3 per week)<br>23. SSI (2 / day x 5 days)<br>24. Daily debrief, data entry, coding | 25. FG discussions (3 per week)<br>26. SSI (2 / day x 5 days)<br>27. Daily debrief, data entry, coding |
| **Week 11** | **Week 12** |
| 28. KI (round 4)<br>29. FG discussions (3 per week)<br>30. SSI (2 / day x 5 days)<br>31. Daily debrief, data entry, coding | 32. SSI (2 / day x 5 days)<br>33. Daily debrief, data entry, coding |

| Week 13 | Week 14 |
|---|---|
| 34. Analysis week<br>34.1. Transcript review<br>34.2. Data cleaning<br>34.3. Secondary & tertiary coding<br>34.4. Preliminary analysis<br>34.5. Preliminary write-up | 35. Analysis week (cont.)<br>35.1. Transcript review<br>35.2. Data cleaning<br>35.3. Secondary & tertiary coding<br>35.4. Preliminary analysis<br>35.5. Preliminary write-up |
| **Week 15** | **Week 16** |
| 36. Dissemination workshop preparation<br>37. Results write-up<br>38. Preparation of presentation materials<br>39. Dissemination workshop | 40. PSI report write-up<br>41. End of activity |
| **Legend:** | KI – key informant in-depth interviews (16 x 4 rounds)<br>SSI – semi-structured interviews (60)<br>FG – fogo cruzado focus groups (15) |

*11.5.1 Summaries of each version of the questionnaire*

**SSI v1**

1 SOCIO-DEMOGRAPHIC DATA
2 YOUTH AND FAMILY LIFE
3 SOCIAL LIFE AS AN ADOLESCENT
4 SEXUAL DEVELOPMENT
5 SEXUAL DEVELOPMENT OVER THE YEARS
6 LAST SEXUAL EXPERIENCE AND CONTRAST WITH PAST YEAR
7 THE FUTURE

**SSI v2**

1. SOCIO-DEMOGRAPHIC PROFILE
2. YOUTH AND FAMILY LIFE
3. SOCIAL LIFE AS ADOLESCENT
4. CASE 1: FIRST SEXUAL EXPERIENCE
5. CASE 2: CONTRAST WITH PAST YEAR
6. EVALUATION OF SEXUAL LIFE
7. SAFE SEX
8. HIV/AIDS and STDs
9. RISK NEGOTIATION & CONDOMS
10.SEXUALITY
11. THE FUTURE

**SSI v3**

1 SOCIO-DEMOGRAPHIC DATA
2 YOUTH AND FAMILY LIFE
3 SOCIAL LIFE AS AN ADOLESCENT
4 CASE 1: FIRST SEXUAL EXPERIENCES
5 SEXUAL DEVELOPMENT OVER THE YEARS
6 CASE 2: CONTRAST WITH LAST YEAR
7 THE NEGOTIATION OF RISK AND CONDOMS
8 THE FUTURE

**SSI v4**

1 SOCIO-DEMOGRAPHIC PROFILE
2 YOUTH AND FAMILY LIFE
3 SOCIAL LIFE AS AN ADOLESCENT
4 CASE 1: FIRST SEXUAL EXPERIENCES
5 CASE 2: CONTRAST WITH LAST YEAR
6 SEXUAL DEVELOPMENT OVER THE YEARS
7 SAFE SEX
8 THE NEGOTIATION OF RISK AND CONDOMS NEGOTIATION OF RISK
9 SEXUALITY
10 THE FUTURE

**SSI v5**

1 SOCIO-DEMOGRAPHIC PROFILE
2 YOUTH AND FAMILY LIFE
3 SOCIAL LIFE AS AN ADOLESCENT
4 CASE 1: FIRST SEXUAL EXPERIENCES
5 CASE 2: CONTRAST WITH LAST YEAR
6 SEXUAL DEVELOPMENT OVER THE YEARS
7 SAFE SEX
8 THE NEGOTIATION OF RISK AND CONDOMS
9 SEXUALITY
10 THE FUTURE

**SSI v6**

1 SOCIO-DEMOGRAPHIC PROFILE
2 YOUTH AND FAMILY LIFE
3 SOCIAL LIFE AS ADOLESCENT
4 CASE 1: FIRST SEXUAL EXPERIENCE
5 CASE 2: CONTRAST WITH PAST YEAR
6 EVALUATION OF SEXUAL LIFE
7 SAFE SEX
8 RISK NEGOTIATION AND PERCEPTIONS OF CONDOMS
9 SEXUALITY
10 THE FUTURE

SSI v6 (EN)

# EQuAR
## PROTOCOL FOR ADOLESCENTS

(ver 6)

BEFORE STARTING, ADMINISTER THE INFORMED CONSENT FORM

## 1 SOCIO-DEMOGRAPHIC PROFILE

### *1.1 Demographic characteristics*

- Interview number
- Name of respondent, age, sex

### *1.2 Family life*

- Current marital status
- Past marital status
- Number of children

### *1.3 Parental situation*

- Marital status of parents
- Occupation of parents
- Names/nicknames, ages, and occupations of siblings

### *1.4 Origin*

- Place of birth (describe)

### *1.5 School*

- Highest level of school achieved
- Type of school attended
- If dropped out, why

### *1.6 Socio-ecomomic situation*

- Occupation of respondent
- Place of residence
- Type of house
- People who live in the same residence

### *1.7 Other important information*

- Religion – degree of importance (1-5), actual practice
- Ethnicity identified, of family

- Ideas about success
  - Role models/idols
  - A successful person looks like
  - Differences between men and women

### *1.8 Sexual communication at home during childhood*

- Sexual education, how it was introduced, by whom, talked about, taught
- Differences between men and women in terms of sexual education/communication
- Information about the use of contraception, condoms, STDs, HIV/AIDS

## 2 YOUTH AND FAMILY LIFE

### *2.1 Family atmosphere*

2.1.1 How was the atmosphere at home when you were a child (less than 12 years old?

How well did you get on with your parents and teachers?

What was the relationship between your parents like?

How would you characterize your mother (or stepmother)?

Did she help you resolve problems?

Family problems

Problems during childhood

2.1.2 Description of relationship with parents

How well did your parents get on?

How did you feel in relation to your parents?

Did they show any (physical) affection toward one another in front of you or your siblings?

Would you characterize your family as one that demonstrated emotional or physical affection?

In your childhood, did you feel that you were treated with caring?

Did you ever feel uncared for, forgotten or abandoned?

Role of mother and father at home

2.1.3 Description of relationship between siblings

Did you get on well with your siblings?

How did you feel in relation to your siblings?

Were there any sources of tension in the house?

Hierarchy at home

Rivalry between siblings

2.1.4 Description of relationship to others

People close to you (non-immediate relatives, friends, neighbours)

Joint activities

Childhood friends

Role of extended family

2.1.5 Childhood environment

Number of friends outside the home

Games played with friends

Cohesiveness of community

Type of area (rural, urban)

### *2.2 Self esteem*

2.2.1 Behaviour during childhood

Were you a typical child?

SSI v6 (EN)

Did you have a happy childhood?

Why, why not?

2.2.2 Were the rules of the house clear?

Were your parents very strict?

Were there rules useful?

Were they just?

Were the rules flexible?

How were the rules enforced?

2.2.3 Did anyone ever try to do something sexual to you when you were a child that you didn't want them to do? (brief description)

Was there any unwanted sexual situation (brief description)

2.2.4 Was there any emotional neglect? (brief description)

2.2.5 Did you suffer from any physical abuse or violence when you were a child? (brief description)

Was there ever any violence in your childhood? (brief description)

*2.3* ***The nature and extent of sexual information in the family during childhood***

2.3.1 Was sex talked about in the house when you were a child (less than 12 years old)? Were issues about conception, contraception, condoms, STDs, AIDS discussed?

2.3.2 What ideas about sex were taught by your parents and by other members of your family?

What were you taught about sex when you were a child?

What kind of sexual education was given to you?

Who initiated the discussion? What was said and did this change according to age?

Where changes in your body (puberty) discussed?

[for girls] Was your first menstruation discussed?

What obvious messages and implicit messages about sex did you learn?

Were the rules the same for boys and girls?

What sources of information about sex did you have in your childhood?

Were they the same sources you used when you got older (than 12 years)?

Did you even see or hear anyone having sex? If yes, who?

Puberty for respondent or for others

Growing up

Comfortableness with sexuality

## 3 SOCIAL LIFE AS ADOLESCENT

***3.1 The principal events during adolescence that changed the way s/he though, acted, felt***

- Describe the best and worst events during adolescence
- Explore if these events are still important today

***3.2 Current social life***

- Type of activities currently involved in
- Places to have fun/hang out
- Number/type of friends
- Consumption of alcohol and recreational drugs

***3.3 Well being***

- Physical, emotional, and metal state of health
- Type of help/assistance sought

- How problems are faced

### *3.4 Social networks*

- Turn to whom to talk about problems
- With whom can one speak to about intimate/sensitive topics (menstruation, masturbation, pregnancy, STDs, HIV/AIDS)
- Why turn to this/these individuals and not others
- What type of connection is there with these individuals
- What type of environment is easiest to speak about such topics

## 4 CASE 1: FIRST SEXUAL EXPERIENCE

### *4.1 Sexual development*

- Describe first sexual feelings
- Describe first time approached in a sexual way
- How one dates/courts (namorar) prior to becoming sexually active

### *4.2 First sexual relations*

- Context – when, where, type of environment, if planned, duration
- Type of partner – age, known before and for how long, level of intimacy
- Expectations
  - Motivation for sex on the part of both partners
  - Feelings about first sexual experience in terms of emotional factors, physical experience at the time of sex
  - Expectations of partner in terms of sexual act, the individual, of the relationship
- protection
  - Form of communication on whether to use protection
  - Use of protection for pregnancy, STDs, HIV/AIDS
  - Risks consideraded
  - How prepared was individual, partner to use contraception
- Sequence of sexual act
  - Suggestion of sexual acts
  - Capacity to influence the events in the act
  - Pleasure/orgasm reached
  - Control over the process leading to the sexual experience
  - The influence of other factors in the process

## 5 CASE 2: CONTRAST WITH PAST YEAR

### *5.1 Last sexual experience*

- See section 4.2 of guide

### *5.2 Partners in past year*

- Number of partners with whom respondent has had penetrative and non-penetrative sexual relations in the past year
- Number of male/female partners
- Types of partners
- Type of sex practices with each partner type
- Most common practices per partner type
- Frequency of sexual relations
- Duration of sexual relations per partner type
- Gave/received money for sex in past year

### *5.3 Feelings about sex*

- Importance/meaning of sex
- What is sought in having sex

- Thoughts or feelings associated with sex and after sex

### *5.4 Sexual risk and protective practices*

- Condom use – frequency, motive, circumstances, feelings
- Difference using condoms by partner type
- Type of contraception used
- Decision to use condoms
- Risk assoicated with sexual relations
- Probability/risk of getting HIV/AIDS

## 6 EVALUATION OF SEXUAL LIFE

### *6.1 Personal sexual history*

- Detailed sexual history from first sexual relations to most recent
- Types of partners
- Gave/received money for sex anytime
- Type of sex practiced with each partner type
- Forms of protection againsts STDs, HIV/AIDS, pregnancy
- Negotiation of the use of contraception
- How protection is obtained
- Duration of relationship before having sex
- Duration of relationships by partner type
- Number of sexual partners during sex
- Male and female partners
- Control of sexual life – means of control, meaning of control

### *6.2 Reflection over sexual development and changes along sexual career*

- Best and worst (consensual) sexual relations
- Current sexual satisfaction
- Changes over sexual life
- Time spent thinking/procuring sex
- Meaning and feeling about sex and relationships in general
- How HIV/AIDS changed sexual life

## 7 SAFE SEX

### *7.1 HIV/AIDS and STDs*

- Does it exist, how it is caused, difference between (HIV and AIDS), types of cures, symptoms
- How HIV/AIDS has altered sexual relations
- Fear of HIV/AIDS (why afraid? Afraid of death, of being infected, of others reaction)
- HIV test (already tested, plan to test, would disclose, to whom)

### *7.2 Condoms*

- Use condoms, don't use condoms, why? Use with what partner types, why, significance of using them
- Friends use condoms
- Conversations about condoms
- Advantages and disadvantages of using condoms
- Effectiveness of condoms
- How to get condoms (purchase, free, where, barriers)
- Heard of Jeito condoms

- Why called Jeito

### *7.3 Sexual practice and prohibitions*

- Ideal age to start sexual relations (how does this differ by men and women)
- Safe sex (explain)
- Dry sex (explain)
- What is the effect of delaying ones sexual life (virginity, abstinence)
- When should one abstain from having sexual relations

### *7.4 Pregnancy and childbirth*

- Attitudes in relation to unwanted pregnancy
- Means of avoiding pregnancy, STDs, HIV/AIDS
- Attitudes about abortion

## 8 RISK NEGOTIATION AND PERCEPTIONS OF CONDOMS

### *8.1 Risk negotiation*

- Communication with partner about STDs, HIV/AIDS and unwanted pregnancy
- Partners with whom one can speak about such topics
- Contemplation of strategies to reduce risk
- Attempts to reduce risk, to what degree succeeded

### *8.2 Types of partners and their characteristics*

- Differences between main boy/girlfriend and other types of relationships
- Sleeping with someone only once is what type of relationship
- What's the riskiest type of sex

### *8.3 Sexual interactions*

- Events resulting in sex
- Sexual activities practiced
- Control of sexual relations

### *8.4 Sexual pressure*

- Definition of sexual pressure and sexual violence
- Used/suffered from sexual pressure
- How has knowing someone who was raped/forced to have sex has influenced your own experiences
- If partner wants to have sex but you don't, what happens? Sexual violence? How would partner react?
- If you wanted to have sex and your partner did not, what would you do? Would pressure be appropriate?
- If sex is demanded/forced, is it rape or coercion? How would the partner react?
- Who exerts sexual pressure, the man or woman?
- Under what conditions is sexual pressure or use of force acceptable
- Perception of gang rape, is it ever justified?

## 9 SEXUALITY

### *9.1 Masturbation*

- Frequency
- Importance
- Patterns of masturbation

### *9.2 Formation and initiation of sexual of relationships*

- Manner relationships are initiated between men and women

- Ideal age for young men and women to start sexual relations

### *9.3 Commercial sex*

- Definition
- Acceptability
- Motivations for engaging in commercial sex – both as sex worker or as client
- Use of condoms with a sex worker
- Type of acts acceptable with a sex worker

### *9.4 Homosexuality*

- Does sex between men and between women happen? (when, how, acceptability)
- How does (Mozambican) society view this practice
- What are the various names given to this practice
- Is group/simultaneous masturbation among the same sex the same thing
- Does cross dressing indicate homosexuality
- Would non-penetrative sex between the thighs (intra-crural sex) between boys be considered homosexuality

## 10 THE FUTURE

### *10.1 Future prospects for the respondent*

- Respondent optimistic or pessimistic about the future
- What would you like to be or do in the future in terms of school, family, work, relationships (sexual and others)

### *10.2 Future sexual life and perceptions of risk*

- Describe your ideal sexual life
- What mechnisms of protection against STDs, HIV/AIDS, and unwanted pregnancy would you use
- What do you think about your sexual risks in the future
- What types of future relationships do you hope for
- What attitude do you and other young people have regarding condoms

### *10.3 End of interview and reflection*

- Feelings about the interview
- Were there important issues not covered

FGD v4 (EN)

## Introduction

My name is _____, I am the moderator of this group and form part of a group that is at this moment conducting a study among young people with the objective of collecting information in the area of reproductive health. Accompanying this activity are a number of other people to help us, they are a note-taker Mr/s _____, and an observer Mr/s _____.

This focus group is part of a project that deals with the sexual health of adolescents. The activity is supported by the Ministry of Health with the assistance of various international donors. The objective of the study is to investigate what young people here in Maputo thing about issues of sexuality, of reproductive health, such as sexual educton, contraception, and the risks associated with sexually transmitted diseases. We are interested in hearing your frank opinions.



There are no correct or wrong answers, all of your opinions are valid. We will not ask for specific details about your personal experiences. It is important that it is clear that anything said in this room will not be repeated to anyone who is not currently present here. Everything that is said in this room will be confidential and anonymous.

After transcribing the interview, all the names of persons and of places will be eliminated or substituted for fictitious names in order to protect the identity of the participants. It is important to repeat that participants are not obligated to respond to any question they choose not to.

In this discussion, we are going to talk about men and women of your age. All of your opinions are valid and very important to us, with your permission, we would like to record the conversation.

Is there any question about this activity or about how we plan to go about doing it? Can we begin?

Before we begin the discussion, we would like to administer a short questionnaire that will only take about 5 minutes to finish.

Thank you.

ADMINISTER INDIVIDUAL QUESTIONNAIRE AND CONSENT FORM WITH EACH PARTICIPANT.

# FOCUS GROUP GUIDE

1. **Talking about sex, STDs, AIDS, pregancy, and masturbation**
   1.1. Do people of your age talk about sex?
   - Why, how, when
   - With friends
   - parents
   - partners
   - other people
   - differently with father and mother
2. **Pressure and sexual consent**
   2.1. What does sexual pressure (coercion) mean to you?
   - When to pressure
   - Who pressures, men or women

   2.2. Pressure is acceptable?
   - Opposing pressure, what can be done
   - Difference between pressure (coercion) and rape
   - Gang rape (geral), is it acceptable
   - Dress / seduction
3. **Risk and responsibility**
   3.1. Do young people your age think agbout the risks associated with sex?
   - What risks
   - What are the risks for men
   - For women
   - How are risks confronted
   - Risks of HIV/AIDS and pregnancy

   3.2. Who is responsible for protection?
   - What are the forms of protection for each type of partner
   - What types of partners can one have
   - What are the forms of protectoin and types of risk
4. **The negotiation of risk**
   4.1. Does risk vary according to the type of partner?
   - Sex workerl
   - acceptability
   - condom use in commercial sex
   - money, presents and commercial sex
   - difference between stable partner and sex worker
   - motivation for using commercial sex (men/women)
   - communication about STDs, HIV/AIDS with various types of partnrs
   - problem in ignoring
   - advantages of confronting
   - insistence on using a condom
   - (In)fidelity and risk (increase/decrease)
   - number of partners / reputation (men – women)
5. **Condoms**
   5.1. If a partner offered a condom, how would you interpret his/her attitude?
   5.2. use of condoms with each type of partner
   - sex worker
   - Difference
   - Reasons/significance of using
   - Motives for using/not using
   - Advantages of condoms
   - Comparison of condoms

**6. HIV/AIDS and STDs**

6.1. what is HIV/AIDS? What's the difference between the two?

. AIDS exists?
. Causes – most plausible
. Symptoms
. Forms of prevention
. Forms of treatment

6.2. Know of someone with HIV/AIDS?

. Life expectancy with HIV/AIDS
. Influence on sexual behaviour

6.3. Do you think people (your age) are at risk of HIV/AIDS?

. Probability of infection from unprotected sex
. Process of infection with HIV/AIDS
. Process of infection with STDs
. Types of STDs
. Attitude in relation to partner(s)

**7. Safe sex, condoms, and promotional campaigns**

7.1. Do you think that a younger partner offers some security in terms of HIV/AIDS or STDs?

. Strategies to reduce risk
. Other forms of prevention
. Social status and STDs/HIV/AIDS
. Non-penetrative sex - alternative
. Governement/non-government campaigns - influence on sexual behaviours
. Solutions for the adoptoin of safe sex
. How to guarentee partner is not infected

**8. Sex and sexuality**

8.1. what is sex, the act, and sexual relations?

. What contexts, processes lead to sex (safe/unprotected)
. Penetration / sexual act
. Oral sex, anal sex, masturbation
. Duties (responsibilities) of men/women

**9. Practices and sexual prohibitions**

9.1. At what age should someone start having sexual relations?

. Sex with a pregnant woman
. Sex during menstruation
. Sex after recent abortion
. Sex after widowhood

9.2. Does the presence of a STD change one's sexual behaviour?

. Infected partners and sexual relations
. Can one starts sexual relations at an advanced age?

**10. Homosexuality**

10.1. Sex between men and between women occurs? (when, how, acceptability)

. How does society view this practice?
. Names given to this practice
. Simultaneous masturbation,
. Inter-thigh sex
. Cross-dressing

**11. Perceptions of the scripts presented in the fogo cruzado**

11.1. The Fogo Cruzado just presented reflects a realistic situation?

. In real life, what could a man or woman do to convince her partner to use a condom?
. If the majority of participants respond that the man must [convince], ask: why not the women?
. Who should take the initiative for negotiating, the man or woman?
. If the negotiation fails, what should they do?

11.2. Can you think of other situations where this negotiation would create other results?

. What type of impediments could arise in a negotiation like the one we've just seen?
. What could a partner do to overcome any impediment that might arise during a negotiation?

## *11.5.4 Screening questionnaire for focus group participants*

**Questionnaire for Focus Group Participants**

| | | |
|---|---|---|
| Date of birth of respondent | [MONTH/YEAR] | ____/____ |
| | ELLIGIBLE AGE (16-35) | ___ → 2 |
| | NOT ELIGIBLE | ___ → END |
| Sex of respondent | | M / F |
| Highest class attained | | ___ |
| Currently studying? If yes, full-time or part-time? | | ___ FT/PT |
| How many times have you listened to the radio in the past 4 weeks? | | ___ |
| How many times have you watched television in the past 4 weeks? | | ___ |
| how many times have you consumed alcohol in the past 4 weeks? | | ___ |
| How long have you lived in Maputo? | | ___ |
| Have you lived in any other place for 1 month or more in the past year? | YES | ___ |
| | NO | ___ |
| **What religion do you belong to?** | | _____ |
| What is your principal language? | | _____ |
| What is your secondary language? | | _____ |
| At this time, are you employed or engaged in any temporary labour? | YES | ___ |
| | NO | ___ |
| What is your monthly income? | | _____Mts |
| With whom do you live? | | _____ |
| How many people live in your house? | | _____ |
| What is the principal source of transport that you use? | | _____ |
| Are you married or cohabitating with someone for a year or more? | YES | ___ |
| | NO | ___ → 20 |
| When did you marry or start living maritally (cohabitating)? | [MONTH/YEAR] | ____/____ |
| Have you ever married or lived maritally in the past? | YES | ___ |
| | NO | ___ → 23 |
| When did it end? | [MONTH/YEAR] | ____/____ |
| How did it end? | DIVORCED | ___ |
| | SEPARATED | ___ |
| | WIDOWED | ___ |
| How many children do you have? | 0 | ___ if '0' → 24 |
| | 1 | ___ if '1' → 26 |
| | +1 | ___ if '2 or more →25 |
| Have you ever had sex? | YES | ___ → 26 |
| | NO | ___ → 26 |

| | | |
|---|---|---|
| With how many different people do you have children? | | ___ |
| Have you ever had a boy/girlfriend in the past? | YES | ___ |
| | NO | ___ |
| Do you have a boy/girlfriend currently (besides your spouse if you have one)? | YES | ___ |
| | NO | ___ → 30 |
| How much time have you been with this most recent boy/girlfriend? | [MONTHS] | ___ |
| Have you had sex with your current boy/girlfriend? | YES | ___ |
| | NO | ___ |
| Do you have other friends with whom you have sexual relations? | YES | ___ |
| | NO | ___ → 32 |
| In the past year, how many different friends have you had sexual relations? | | ___ |
| The last time you had sexual relations, it was with whom? | SPOUSE | ___ |
| | BOY/GIRLFRIEND | ___ |
| | FRIEND | ___ |
| | UNKNOWN PERSON | ___ |
| Did you use a condom the last time you had sex? | YES | ___ |
| | NO | ___ |
| What is the frequency that you use condoms with this most recent partner? | ALWAYS | ___ |
| | ALMOST ALWAYS | ___ |
| | SOMETIMES | ___ |
| | NEVER | ___ |
| When was the first time you had sexual relations? | [MONTH/YEAR] | ____ / ____ |
| Did you use a condom the first time you had sex? | YES | ___ |
| | NO | ___ |
| Have you ever received or given money in exchange for sex? | YES | ___ → 39 |
| | NO | ___ → 39 |
| Do you know what a condom is? | YES | ___ |
| | NO | ___ |
| Do you know where to get a condom? | YES | ___ |
| | NO | ___ |
| Have you ever purchased a condom? | YES | ___ |
| | NO | ___ |
| Have you ever heard of HIV/AIDS? | YES | ___ → END |
| | NO | ___ → END |

## 11.6 Research team

| NAME | AFFILIATION | ROLE |
|---|---|---|
| Andrew S. Karlyn | LSHTM / CPS | Principal Investigator |
| Fátima Mussá | PSI / Maputo | Supervisor |
| Aurélio Miambo | UEM / UFICS | Research Assistant |
| Benjamim Macuácua | PSI / IEM | Research Assistant |
| Felipe Bila | UEM | Research Assistant |
| Carlota Inhamussua | PSI / Maputo | Research Assistant |
| Cidália Nhancale | UEM / UFICS | Research Assistant |
| Maria Ivone Felimone | UEM / UFICS | Research Assistant |
| Ezequiel Mingano | PSI / Maputo | Research Assistant |
| Gilda António | PSI / Maputo | Data entry clerk |
| Luísa Novele | PSI / Maputo | Data entry clerk |
| Maria do Céu Sivé | UEM | Data entry clerk |

## 11.7 Informed consent

**FICHA DE CONSENTIMENTO**

| | |
|---|---|
| Investigador: | Andrew S. Karlyn |
| Instituição: | London School of Hygiene and Tropical Medicine – London, UK<br>Population Services International – Moçambique<br>Programa Nacional de Controle das DTS e SIDA, Ministério de Saúde – Moçambique |
| Título de Projecto: | Construção Social de risco em Moçambique: Evolução da mudança do comportamento da teoria do Script' |
| Objecto de Estudo: | O Projecto visa a necessidade de estabelecer uma intervenção efectiva para a prevenção HIV na comunidade através de análise das normas culturais e sociais que afectam o comportamento do alto risco. |
| Declaração de Confidência | Serão feitas perguntas aos participantes para cobrir os tópicos de saúde reprodutiva e sexualidade com o objectivo de traçar estratégias mais efectivas de prevenção do SIDA. A entrevista será conduzida individualmente e, em grupos. Anotações e gravações serão usadas para o arquivo de dados.<br><br>Toda a informação recolhida através desta pesquisa permanecerá confidencial e limitada para o uso do Projecto de prevenção da PSI e do Programa Nacional de Controle das DTS e SIDA (PNC DTS / SIDA) do Ministério de Saúde.<br><br>Em nenhum momento os nomes, endereços ou outros dados pessoais serão divulgados para o público ou Instituições Comerciais . As gravações serão transcritas e salvaguardadas através do código pessoal de informações associadas ao indivíduo (incluindo o nome, residência e outros detalhes distinguidos). Detalhes pessoais transcritos serão então apagados.<br><br>Depois de limpar, os dados serão arquivados num local seguro pelo PSI e permanecerá propriedade da PSI e PNC.<br><br>O relatório produzido a partir da análise de dados serão apresentados em encontros internacionais exceptuando guias de confidência e moral. |

"Eu entendo a informação fornecida a respeito deste estudo e levarei parte de estudo no que for necessário ".

"Minha pergunta acerca do estudo foi respondida pelo principal investigador ou alguém designado representante."

"Eu entendo que qualquer altura como desenhador deste estudo posso terminar sem dar razão e sem afectar o meu cuidado e directoria.".

"Aceito fazer parte deste estudo.

| **Inquirido:** | **Inquiridor:** | **Supervisor:** |
|---|---|---|
| Assinatura: | Assinatura: | Assinatura: |
| Data: | Data: | Data: |

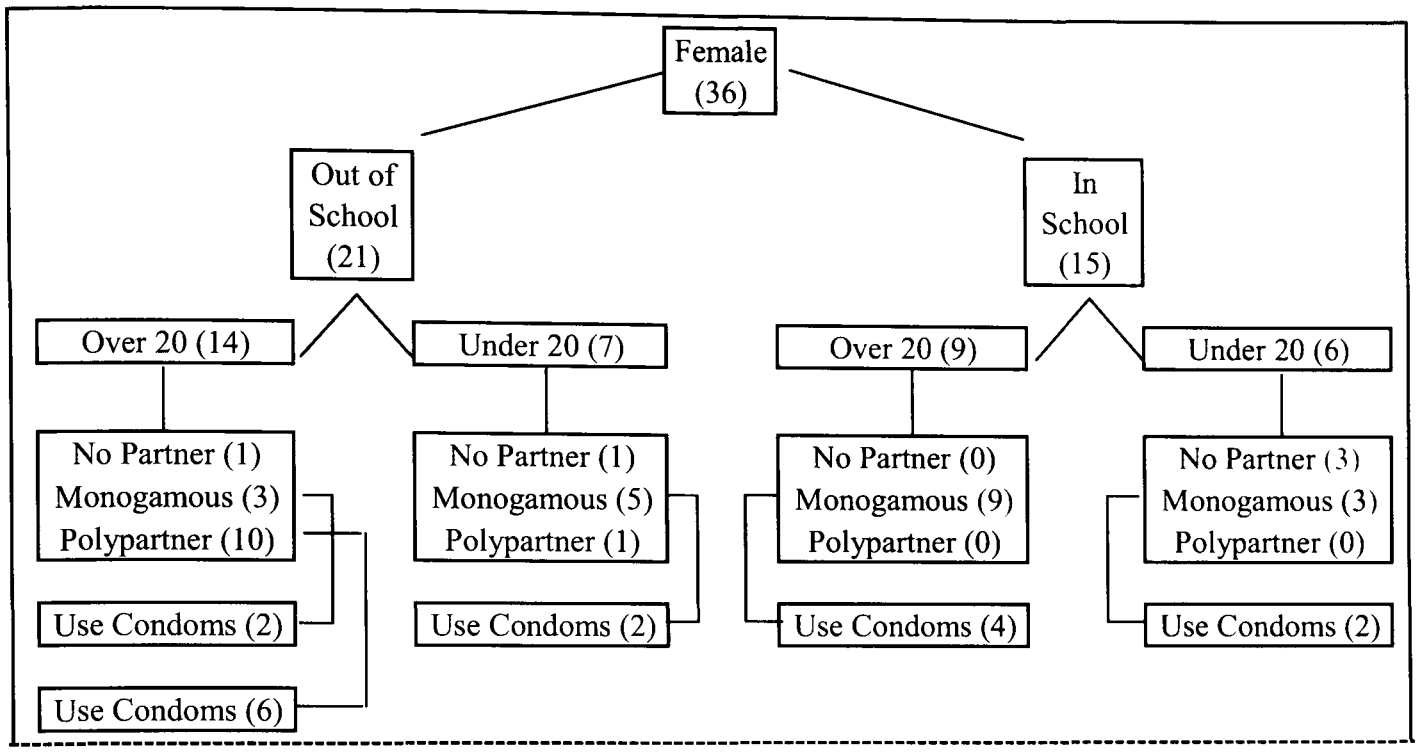
## 11.8 Themes and codes

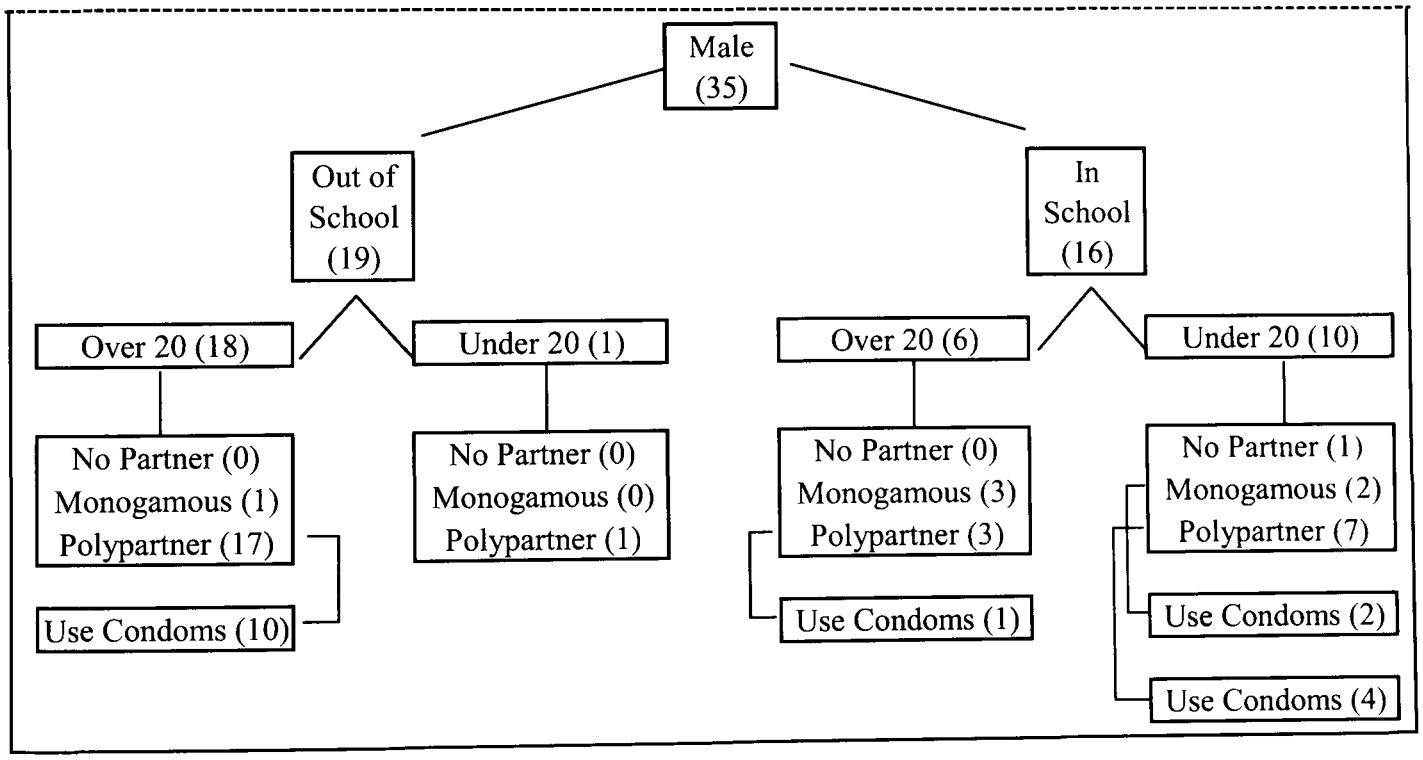
### *11.8.1 Partner type and sexual practice coding scheme*

| Nº | Acto Sexual | Penetração | | | | Sentido | | | | Tipo de relação | | | | Satisfaz | | | Risco | | Nº Parceiros | | | UP | | Aceite | | Idade | | Aproximação | | | Sentimento | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | vaginal | oral | anal | não penetrativo | M > H | H > M | H <> M | H <> H | Casado | Coabitan | Ocasiona | Parceiro Estável | Homem | Mulher | Ambos | Alto | Baixo | Nulo | 1 | 2 | Vários | Sim | Não | Aceite | Não Aceite | Jovem | Adulto | Pouco | Muito | Nulo | Agrada | Passivo | Agrada Activo |
| 1 | Boquete | | X | | | X | | | | X | X | X | X | X | | | | X | | | X | | X | | X | | X | X | | X | | | X |
| 2 | Broche | | X | | | X | | | | X | X | X | X | X | | | | X | | | X | | X | | X | | X | X | | X | | | X |
| 3 | Chupar Piça | | X | | | X | | | | X | X | X | X | X | | | | X | | | X | | X | | X | | X | X | | X | | | X |
| 4 | Chupar Banana | | X | | | X | | | | X | X | X | X | X | | | | X | | | X | | X | | X | | X | X | | X | | | X |
| 5 | Sorvete | | X | | | X | | | | X | X | X | X | X | | | | X | | | X | | X | | X | | X | X | | X | | | X |
| 6 | Minete | | X | | | | X | | | X | X | X | X | | X | | | X | | | X | | X | | X | | X | X | | X | | | X |
| 7 | Orgia | X | | | | X | | | | X | X | X | X | | | | X | X | | | X | | X | X | X | | X | X | | X | | X | |
| 8 | Sexo Molhado | X | | | | X | | | | X | X | X | X | | | | X | X | | | X | | X | X | X | | X | X | | X | | | X |
| 9 | Sexo Seco | X | | | | X | | | | X | X | X | X | | | | X | X | | | X | | X | X | X | | X | X | | X | | | X |
| 10 | Bacia | X | | | | X | | | | X | X | X | X | | | | X | X | | | X | | X | X | X | | X | X | | X | | | X |
| 11 | Frango Assado | X | | | | X | | | | X | X | X | X | | | | X | X | | | X | | X | X | X | | X | X | | X | | | X |
| 12 | Chuva Dorada | X | | | | X | | | | X | X | X | X | | | | X | X | | | X | | X | X | X | | X | X | | X | | | X |
| 13 | T.V. Satélite | | X | | | | X | | | X | X | X | X | | | | X | X | | | X | | X | X | | | X | X | | X | | | X |
| 14 | Traseira | | X | | | | X | | | X | X | X | X | | | | X | X | | | X | | X | X | | | X | X | | X | | | X |
| 15 | Rabar | | X | | | | X | | | X | X | X | X | | | | X | X | | | X | | X | X | | | X | X | | X | | | X |
| 16 | 69 | | X | | | | | X | X | | X | X | X | | | | X | X | | | X | | X | | | | X | X | | X | | | X |
| 17 | Punheta | | | | X | | X | | | X | X | X | X | | | | | X | | | X | | X | X | | | X | X | | X | | | X |

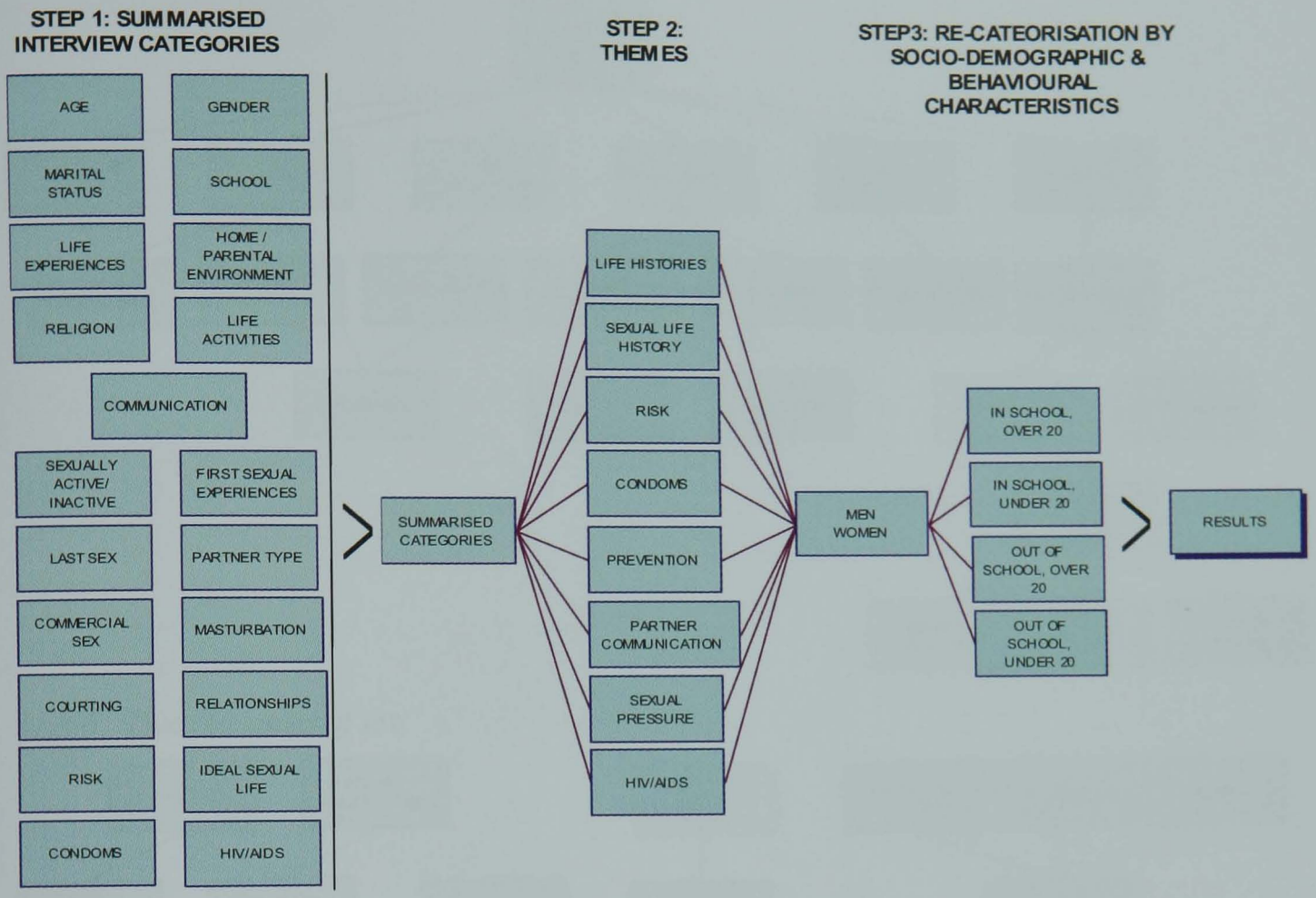
*11.8.2 Categorical organisation of interview data*

***Graphic 14: Categorisation of individual interviews by sex, school, age, partner type, and condom use***

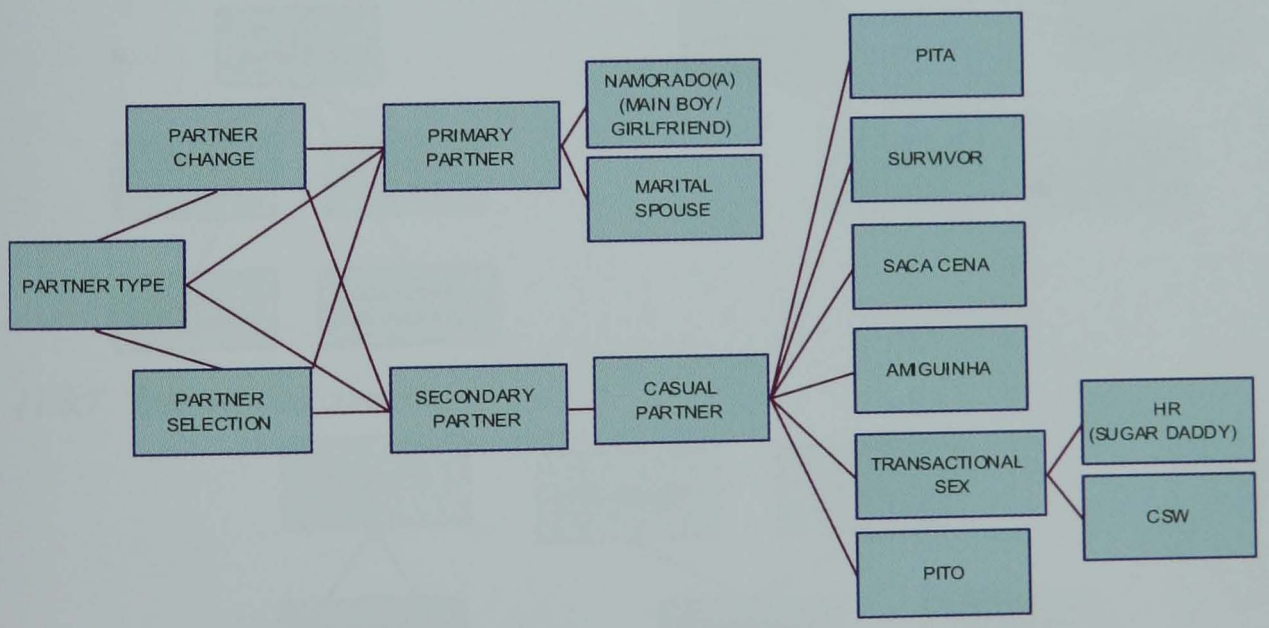


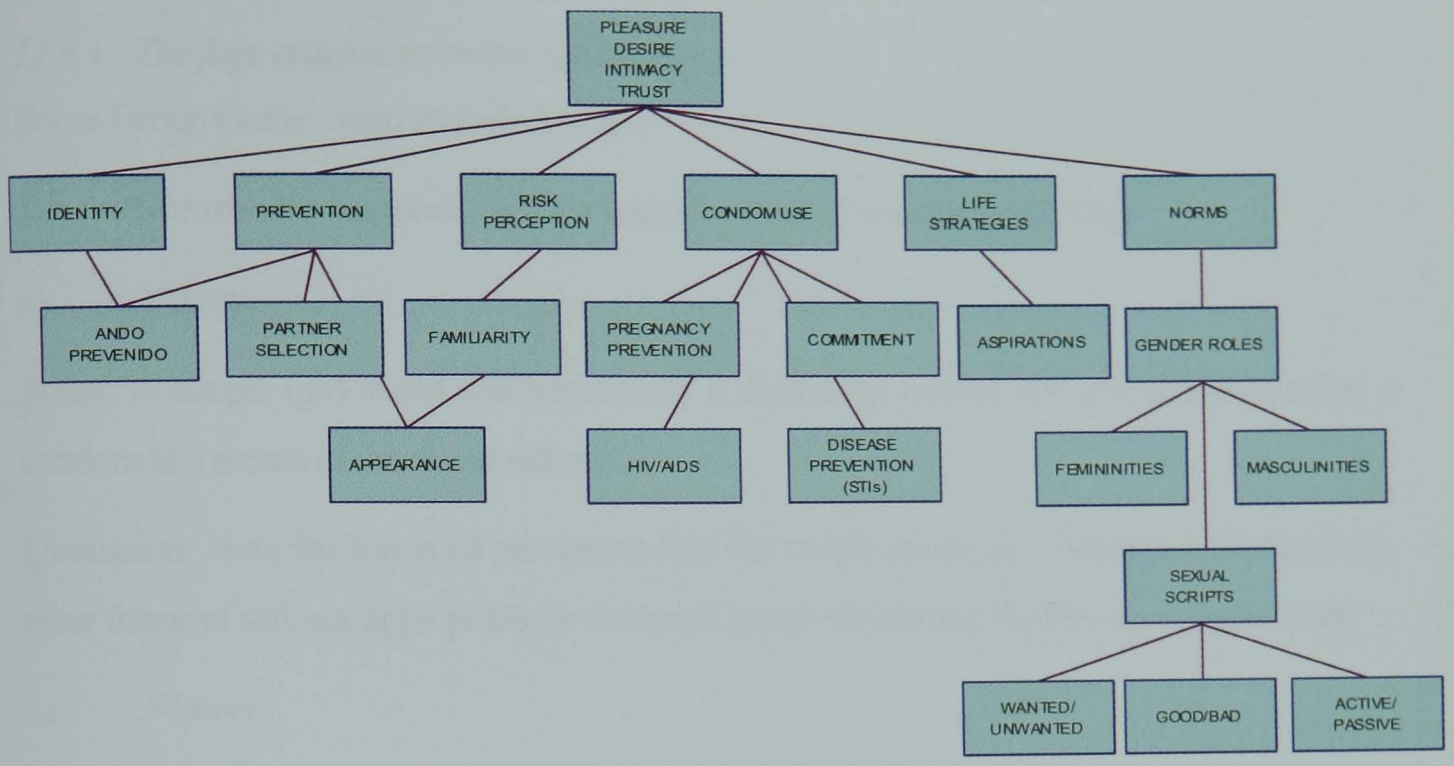
### *11.8.3 Data summary*



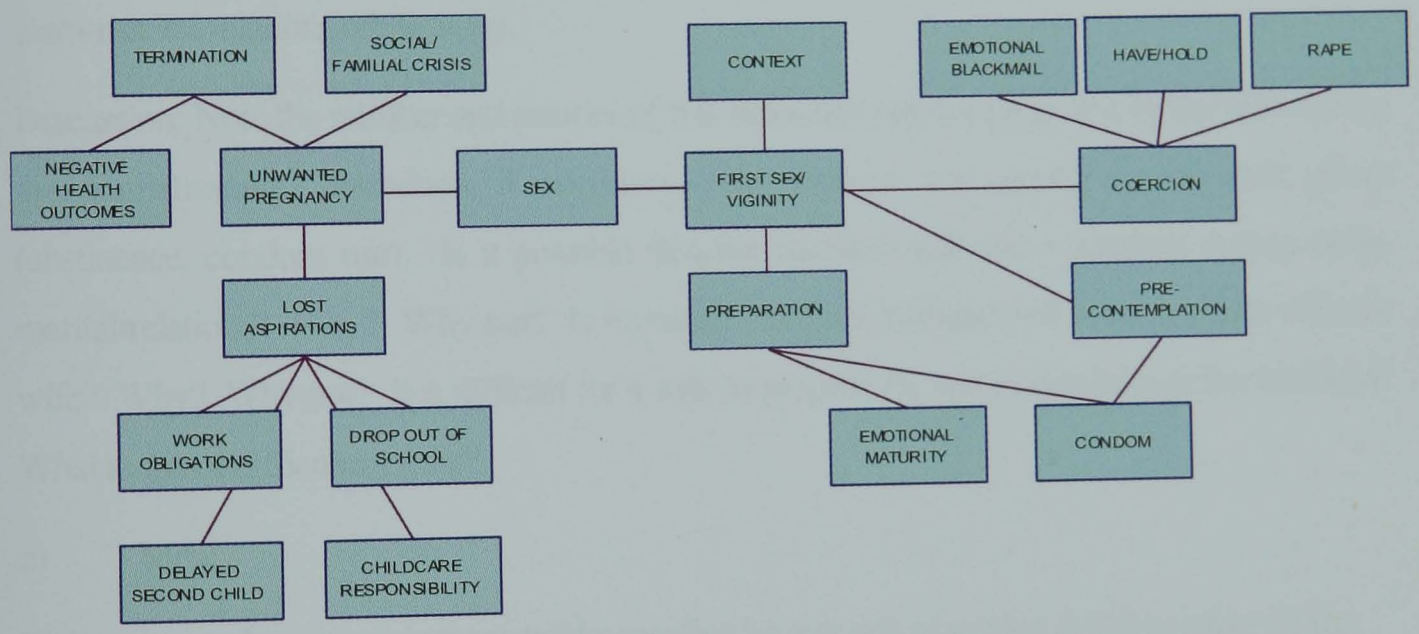

### *11.8.4 Partner type*



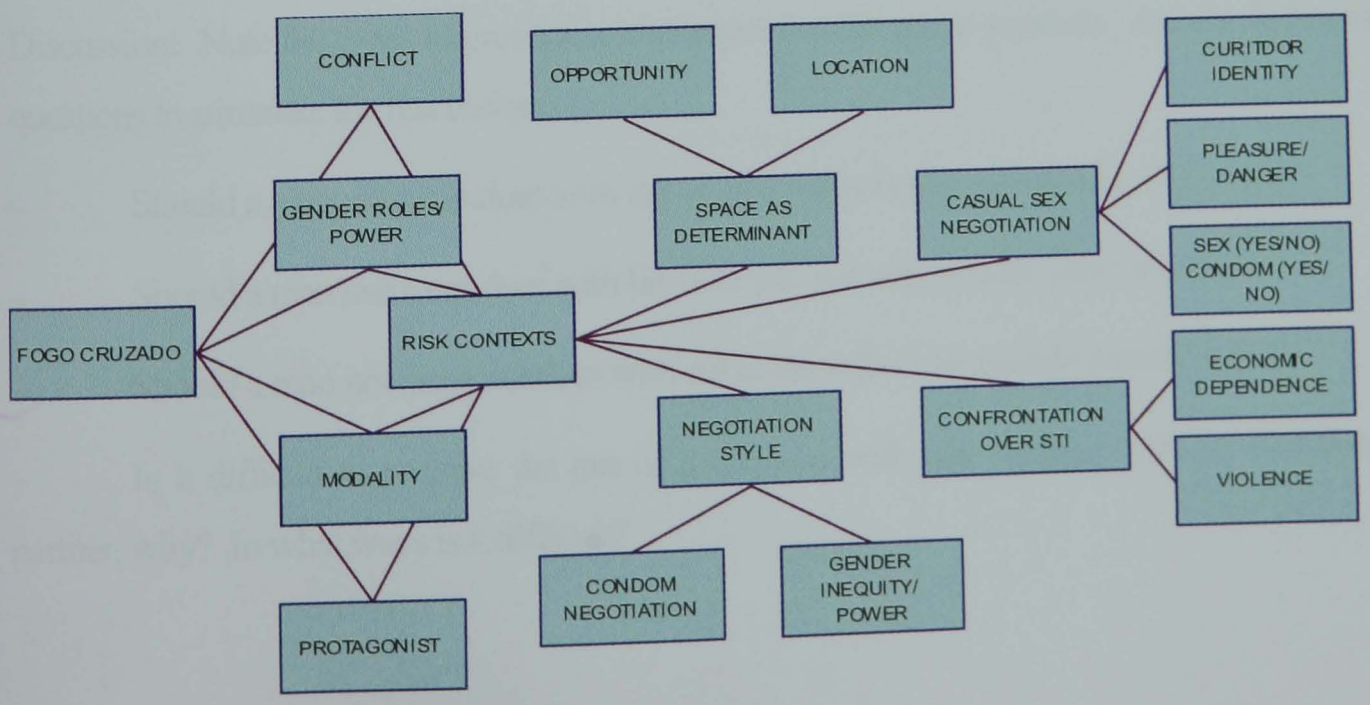
### *11.8.5 Identity, appearance, risk*




### *11.8.6 Two outcomes of sex*




### *11.8.7 Intervention contexts*



## 11.9 *The fogo focal* methodology and moderator guide

### *11.9.1 The fogo cruzado narrative methodology*

Focus Group Guide - fogo cruzado Module

1. Scenario #1: negotiate safe sex using the topic of avoidance of STDs

a) Youths:

Script: A couple (girl-friend and boy-friend) is discussing having sex, one proposes using a condom as a means of practising safe sex.

Discussion: Note the forms of prevention that the couple presented. Introduce, if necessary, other forms of safe sex appropriate for the target group (abstinence, fidelity, and condom use)

b) Women:

Script: A wife, whose husband is a long-distance truck driver, suspects that her husband has extra-marital relations while away.

Discussion: Note the number and priority of risk reduction options proposed by the wife during the dramatisation. Introduce, if necessary, other options appropriate for this risk group (abstinence, condom use). Is it possible that her husband will use a condom during extra-marital relations? Why? Why not? Is it possible that the husband will use a condom with his wife? Why? Why not? Is it difficult for a wife to propose the use of condoms to her husband? What kinds of difficulties exist?

c) Men:

Script: A man has many partners and knows that he is at risk of getting AIDS or other STDs.

Discussion: Note the types of prevention messages that the group presents. Ask the following questions to stimulate the discussion:

– Should a man use a condom with occasional partners and not with his wife, why?

– Should a man use a condom with his wife and not with outside partners, why?

– Should a man not use a condom with either his wife or an outside partner, why?

– Is it difficult to propose the use of a condom with your wife or with an occasional partner, why? In what ways is it difficult?

2. Scenario #2: Negotiate safe sex without mentioning STDs or AIDS

a) Youth:

Script: A couple (girl-friend and boy-friend) is discussing having sex, one proposes using a condom as a means of practising safe sex.

Discussion: Note the forms of prevention that the couple presented. Introduce, if necessary, other forms of safe sex appropriate for the target group (abstinence, fidelity, condom use)

b) Women:

Script: A woman heard from her colleagues at work about condoms. Propose to your husband to experiment with a condom.

c) Men:

Script: A long distance trucker, during his trip, proposes using a condom with an occasional partner.

Discussion: In each of the above cases (women and men), note the following aspects:

– How can one talk about using a condom without mentioning STDs or AIDS?
– Can you talk about safe sex without talking about diseases?
– Is it due to a lack of ability/vocabulary?
– Is it because people don't like to talk about it?
– Is it because of cultural issues (traditions, myths, and taboos)?
– Is it because of a lack of practice?

### *11.9.2 The fogo focal narrative methodology*

**Identification of the partners:**

- Start the debate with an identification of the various partners that exist
- Stimulate the participants to represent stereotypes of the partners as personalities
- Communication about sex
- With whom do the partners speak?
- What kind of language is used with the different kinds of partners?

**Dramatisations:**

*Scene 1: Abstinence and delay of sexual debut*

A boy invites his girlfriend to his house to study. After arrival in his house, they go into his bedroom to listen to music, talk, and the door closes. They start to kiss, caress each other, etc. His intention is to have sex. She also wants to, but she doesn't know what to do because she is young and inexperienced. What does she do?

Questions:

- What are the 'risks' of having sexual relations?
- What are the risks of not having sex?
- What kind of understanding do they have between them?
- How might they bring up the issue of the risk of unwanted pregnancy, STDs, AIDS, etc?

*Scene 2: The one-night stand (saca cena)*

The participant is in a bar and he meets a girl that he knows. He wants to have sex with her and she also appears interested, but he knows that he should use a condom. She's seated at a table at the other side of the bar. How will she react if he sends over a bottle of bear along with a packet of condoms, perhaps hidden in a folded piece of paper. The dramatisation begins as he approaches the table. Don't forget to include the issue of STDs in the conversation.

Questions:

- How will she react?
- Is it embarrassing to pick someone up in this way?
- What are the other ways that he might introduce a condom in this situation? Find two other participants to dramatise a variation on the scene.

*Scene 3: Prevent STDs.*

A woman discovers that she got an STD from her partner. She hasn't had sex with anyone else. After she got treatment from the clinic, she returns home to confront her husband.

Questions:

- How can she broach the issue with her husband?
- If he denies any responsibility, what kind of solution might she find?
- If she doesn't want to confront her husband, or fears doing so, how might she introduce the use of condoms when they have sexual relations or encourage his use of condoms with other partners?

*Scene 4:* *Reduce the barriers to condom usage*

A group of female traders are seated in the market on top of their sacks of maize. By chance, a man whom they know passes in front of the group. The conversation begins from there when one of the women comments that 'he is very handsome'. Another woman responds that she was 'with' him the other night. She tells them all about it. They tried to use a condom but he lost his erection. The other women asked what she did and she explained how she helped him with it.

Questions:

- Do condoms reduce pleasure and feelings for the man?
- What can she do to help him?
- If he refuses to use the condom, what should she do?

### 11.10 Radio campaign materials

The *Jeito* radio advertising campaign is based on key messages contained in the PSI communications strategy, and linked to themes and motifs used in the flagship play '*Só a vida oferece flores'* [Only Life Offers Flowers] and three theatrical sketches: *Jeito com Jeito* [*Jeito* (condoms) with style]; *Essa Mania* [This craze]; and, *Mulheres com Jeito* [Women with style]. The campaign uses characters and scenes from the play with each spot centred around a 'conflict situation' with a modeled resolution. The campaign reinforces the key messages in the plays and makes them available to a much wider audience through the radio. The spots were designed to present the conflict situations in a simple, concise, 'real life context' and give immediate advise in the form of key messages. This advise is meant to impart the 'know-how' to handle an otherwise tense and delicate situation.

The campaign consists of 9 spots in Portuguese, summarised below. Later, the spots were translated into each of the 14 local languages most commonly spoken in Mozambique. The spots target both youth and adults by age and gender. The rap spots emphasise the 'cool' image of *Jeito*, while other spots represent 'real life' situations of young Mozambicans (teenage pregnancy and early HIV infection). All of the spots focus on HIV / AIDS and STIs, while one spot promotes the use of condoms to prevent unwanted pregnancy. Prior to their broadcasting, the spots were exhaustively pre-tested and post-tested among the target audiences. Each of the spots is branded to promote *Jeito* condoms, and ends with the promotional jingle, a key message tag line, the price, and where they are available. What follows is an analysis of the radio text using the semiotic text techniques discussed in the literature review.

Theatre: Only Life Offers Flowers Text

The play 'Only life offers flowers' serves as the 'flagship' interpersonal communications activity employed by PSI to promote behaviour change. PSI commissioned Mozambique's most famous contemporary poet, Mia Couto, to write the play as well as the words to the theme song to accompany the play. The initial success of the play allowed for expansion to other activities and communications materials using the same themes. This included a music video, a music cassette, an comic book, and radio-novella, and telenovella. The radio campaign, also, used the same themes and characters established by the play.

Song to accompany Only Life Offers Flowers Text

It was a dream that you destroyed
A life that's lost its colour
It's so difficult to accept the pain
When it comes from falling out of love

My love, with passion
I come to ask your forgiveness
To give you jmy heart
Because you are the reason of my existence

CHORUS

Let's search together for a solution
Let's make of life the promised land
Because, only life offers flowers

To return is to be sure
To say never again to sadness
For love to have no measure
It's necessary to love life

CHORUS

Your body is a ship
I am water and you are the river
You are the earth and I am the seed
The two of us, we are all people

An affair is something that doesn't last
Like a wind that has passed
Life has taught me
That loving is being two

CHORUS

Let's search together for a solution
Let's make of life the promised land
Make from pain a strength reborn
To give love a little more colour
Because, only life offers flowers

*11.10.1 Radio Spots*

***Table 13: Radio Spot Text***

| | |
|---|---|
| **Spot 1** | Rap spot 40" |
| **Target group** | Youth |
| **Characters** | Rapper's unit |
| **Objective** | *Jeito* is cool |
| **Message** | The youth have to be responsible and live with *Jeito* (double entendre of condom and to be sensible (lifestyle) |
| **Summary** | Squize tells Diketxe that he is a perfect man because he always uses *Jeito* and advises his friend (who never uses a condom) to be careful not to get AIDS and to always us *Jeito* when he is with his girlfriend. |
| **Announcer** | Guys! Let's be responsible. Let's live with *Jeito* |

| | |
|---|---|
| **Spot 2** | 65" |
| **Target group** | Youth |
| **Characters** | Two young males |
| **Objective** | Protection from HIV and unwanted pregnancies |
| **Message** | The youth have to be responsible and live with *Jeito* |
| **Summary** | X is telling his friend Ze about the good time he had the previous evening. Ze asks him if he used *Jeito* and X replies that he never uses condoms. Ze tells X to be careful as their friend Carlitos is in Hospital with AIDS. X asks Ze if condoms really work and Ze replies that they protect from STIs / AIDS as well as prevent unwanted pregnancies. X does not like to use condoms and Ze tells him that he always uses a condom with his girlfriend and that it's cool. X promises to try condoms. |
| **X** | Ze! Where were you last night … we had a fantastic time. |
| **Ze** | And you used *Jeito*? |
| **X** | Aahh… I never use condoms. |
| **Ze** | Be careful my man … Carlitos is in a bad way with AIDS. |
| **X** | But do you think this *Jeito* scene really protects? |
| **Ze** | For sure man, if you use it correctly it not only protects you from STIs and AIDS, but also protects your girlfriend from falling pregnant. |
| **X** | OK man, but I don't like to take a bath with a raincoat on. |
| **Ze** | Listen, I always use *Jeito* when I am with Guida and it's really nice. |
| **X** | Yeah! OK man, I'll give it a try. |
| **Announcer** | Guys! Let's be responsible. Let's live with *Jeito*. |

| | |
|---|---|
| **Spot 3** | 65" |
| **Target group** | Youth |
| **Characters** | Two young females |

| | |
|---|---|
| **Objective** | Protection from HIV and unwanted pregnancies by practising abstinence or by using a condom. |
| **Message** | The youth have to be responsible and live with *Jeito* |
| **Summary** | Y tells her friend Guida that their friend Carla had to leave school because she fell pregnant. Y says that she always uses *Jeito* with her boyfriend to protect herself. Guida tells Y that she decided to wait to have sex, but if she ever did she would not risk falling pregnant. The two girls decide to go and visit Carla and give her their support. |
| **Y** | Hi Guida, everything OK? |
| **Guida** | Yes, I am just a bit worried about Carla. She hasn't been to school for a week. |
| **Y** | Don't you know she fell pregnant? |
| **Guida** | Really, but didn't they know how to use a condom? |
| **Y** | Apparently not, as for myself and Rui we never do anything without *Jeito* |
| **Guida** | You know, Ze and I have decided to wait, but if it ever were to happen I wouldn't risk falling pregnant. |
| **Y** | And that's not all, you would also be protected from STIs and AIDS |
| **Guida** | Let's go and give Carla our support. |
| **Announcer** | Guys. Let's be responsible. Let's live with *Jeito*. |

| | |
|---|---|
| **Spot 4** | 66" |
| **Target group** | Women |
| **Characters** | Marta and her Auntie* |
| **Objective** | Women have to convince their partners to use a condom if they suspect that their partners have occasional sexual relations. |
| **Message** | Women must protect themselves and must try and convince their partners to use *Jeito* |
| **Summary** | Marta tells her Auntie that she suspects that Osvaldo has another woman. Her Auntie tells her that she must convince him to stop those adventures or at least to make sure that he uses *Jeito* if he cannot be loyal.** Marta agrees and is going to try because she loves Osvaldo and does not want to lose him. |
| **Auntie** | Marta! It's been such a long time, and why that sad face? |
| **Marta** | Oh Auntie, it's Osvaldo. |
| **Auntie** | What has he done this time? |
| **Marta** | Auntie, I suspect that he has another woman. |
| **Auntie** | Oh my daughter, be careful. Do you know if he uses a condom? This thing of AIDS is very serious. |
| **Marta** | That's the problem Auntie, I don't think he uses *Jeito*. |
| **Auntie** | Marta, if he loves you he won't put you at risk. Try and convince him to be faithful or at least to use *Jeito*. |
| **Marta** | Yes Auntie, I have to convince him to stop with his adventures. I love him and do not want to lose him. |

| | |
|---|---|
| **Announcer** | Let's convince our partners to use *Jeito*. A packet of 4 condoms for only 500 Meticais. On sale near you. |
| **Comments:** | * This spot was originally written as a talk between mother and daughter. After pre-testing in the northern provinces it was discovered that it was taboo for a mother to give a daughter advice on how to use a condom but that an Auntie could. The reason being that a mother that gave her daughter advice on how to use a condom was a mother without morals.<br>** A second interesting reaction was that women preferred to try and help their partners avoid STIs and HIV even though they knew that their partners were having other relationships instead of summarily ending their relationships. This points clearly to the prevalence of a culture of polygamy in the Mozambican society and this was taken into account when producing this spot. |

| | |
|---|---|
| **Spot 5** | 65" |
| **Target group** | Women |
| **Characters** | Olga and Marta |
| **Objective** | Women have to convince their partners to use a condom if they suspect that their partners have (outside) occasional sexual relations |
| **Message** | Women must protect themselves and must try and convince their partners to use *Jeito*. |
| **Summary** | Marta tells Olga how she tried to get Osvaldo to use a condom. She knows that he plays around and wants him to protect himself form STIs / AIDS. Osvaldo refused to use *Jeito*. Olga tells Marta that they have to help their partners and must continue trying to convince them to protect themselves if they can't be faithful. |
| **Olga** | Marta! Where are you? |
| **Marta** | In the kitchen Olga. I am making dinner. |
| **Olga** | Ummmm, peanut curry. Osvaldo is a lucky man. |
| **Marta** | Lucky but very hard headed … last night I tried to get him to use a condom because of his habit of playing around. |
| **Olga** | Tell me, what did he say? |
| **Marta** | He said he doesn't take a bath with a raincoat on (laughter) |
| **Olga** | He should know that *Jeito* protects us from STIs and AIDS |
| **Marta** | He knows. Even so he refuses. He threatened to leave me if I bother him with that. |
| **Olga** | Marta, we have to help our men. We know hoe they are. With patience we will convince them to use *Jeito* to protect themselves if they can't be faithful. |
| **Announcer** | Let's convince our partners to use *Jeito*. A packet of 4 condoms for only 500 Meticais. On sale near you. |

| | |
|---|---|
| **Spot 6** | 65" |
| **Target group** | Women |

| | |
|---|---|
| **Characters** | Marta and Osvaldo |
| **Objective** | Women have to convince their partners to use a condom if they suspect that their partners have occasional sexual relations. |
| **Message** | Women must protect themselves and must try and convince their partners to us *Jeito* |
| **Summary** | Marta tries to convince Osvaldo to try using a condom. He refuses and asks her if she thinks that he plays around with other women. Marta jokes with him about wanting to see his style with *Jeito* and asks him to try it just for her. Osvaldo agrees to try it. |
| **Osvaldo** | Marta! Martinha! I am home! |
| **Marta** | Osvaldo, you're early today. |
| **Osvaldo** | Yes darling, tonight is going to be a special night. |
| **Marta** | You're so naughty, but we have to talk. |
| **Osvaldo** | What talk, we have to do it! |
| **Marta** | Osvaldo, it's about a serious matter. I would like us to try using a condom today. |
| **Osvaldo** | What, *Jeito*! Do you think I play around with other women? |
| **Marta** | It's not that Valdo, I wanted to see your style with *Jeito*. |
| **Osvaldo** | But it's not the same with *Jeito*. |
| **Marta** | How do you know? It also protects from STIs and AIDS |
| **Osvaldo** | But Marta …. |
| **Marta** | Osvaldo, I never ask you for anything, do it for me. |
| **Osvaldo** | OK Marta, let's try it. |
| **Announcer** | Let's convince our partners to use *Jeito*. A packet of 4 condoms for only 500 Meticais. On sale near you. |

| | |
|---|---|
| **Spot 7** | 65" |
| **Target group** | Men with high risk behaviour |
| **Characters** | Osvaldo and the Doctor |
| **Objective** | Condoms work to prevent STIs and AIDS |
| **Message** | Men must protect themselves from STIs and AIDS by using a condom if they can't be faithful or practice abstinence. |
| **Summary** | Osvaldo goes to the doctor and asks him about AIDS. The doctor tells him that AIDS kills but can be prevented by being faithful to one partner or practising abstinence and that the risk can be reduced by using a condom in all occasional sexual relations. Osvaldo agrees to think about using a condom and the doctor gives him a packet of *Jeito* to help him think about it. |
| **Doctor** | Good morning Mr. Osvaldo, how are you? |
| **Osvaldo** | Well doctor, just a bit worried about this AIDS story |
| **Doctor** | It's not a story Mr. Osvaldo. It's a very serious matter. AIDS kills but can be prevented. |

| | |
|---|---|
| **Osvaldo** | But how? |
| **Doctor** | By changing your sexual behaviour, being faithful to your wife or not having sexual relations |
| **Osvaldo** | But that is very difficult…. |
| **Doctor** | You can also reduce the risk of contamination using the condom in occasional sexual relations. |
| **Osvaldo** | But doctor, does *Jeito* really protect? |
| **Doctor** | Yes, condoms protect if they are used always and correctly. |
| **Osvaldo** | OK doctor, I am going to think about it. |
| **Doctor** | To think better, here, take a packet of *Jeito*. |
| **Announcer** | Let's open our eyes. Let's use *Jeito*. A packet of 4 condoms for only 500 Meticais. On sale near you. |

| | |
|---|---|
| **Spot 8** | 66" |
| **Target group** | Men with high risk behaviour |
| **Characters** | Osvaldo and Francisco |
| **Objective** | Occasional sexual relations without a condom are a serious risk |
| **Message** | Men must protect themselves from STIs and AIDS by using a condom. |
| **Summary** | Osvaldo complains to Francisco that women don't want to have sex without a condom. Francisco tells him that *Jeito* protects everybody from STIs and AIDS. Osvaldo does not like to use a condom but Francisco tells him that AIDS exists and has no cure. Osvaldo agrees to think about using *Jeito*. |
| **Francisco** | Osvaldo, what's wrong? You are very nervous. |
| **Osvaldo** | Man, these women do not know what they want. |
| **Francisco** | Why? |
| **Osvaldo** | Now they don't want to do it without a condom |
| **Francisco** | Osvaldo, they are right. *Jeito* protects us. You know what happened to Alice's boyfriend? |
| **Osvaldo** | What? The guy went to Johannesburg. |
| **Francisco** | No, that guy Ricardo is in hospital. He is very sick with AIDS. |
| **Osvaldo** | And how is *Jeito* going to prevent that? |
| **Francisco** | If you use *Jeito* you protect yourself and others from STIs and AIDS. |
| **Osvaldo** | But I don't like to take a bath with a raincoat on. |
| **Francisco** | Tell me, do you cross the road with your eyes closed? |
| **Osvaldo** | Obviously not. |
| **Francisco** | Osvaldo, open your eyes, AIDS exists and has no cure. |
| **Osvaldo** | It's a good point. I am going to think about it. |
| **Francisco** | Think, but think with a raincoat on. |
| **Announcer** | Let's open our eyes. Let's use *Jeito*. A packet of 4 condoms for only 500 Meticais. On sale near you. |

| | |
|---|---|
| **Spot 9** | 67" |
| **Target group** | Men with high risk behaviour |
| **Characters** | Osvaldo and Alice |
| **Objective** | Use a condom to prevent STIs and AIDS |
| **Message** | Men must protect themselves from STIs and AIDS by using a condom if they have various sexual partners. |
| **Summary** | Osvaldo tells his second partner Alice that Marta (his wife) wants him to use a condom. Alice says that she agrees with Marta and that a condom protects as there is a lot of disease around. Osvaldo asks her if he looks sick and Alice tells him that even a person that looks healthy can be infected. Osvaldo agrees to think about using a condom and Alice tells him to think about it with *Jeito*. |
| **Osvaldo** | I love you Alice. You are the only one |
| **Alice** | You liar, and your wife? |
| **Osvaldo** | Ah, that one. Imagine, she wants to try using a condom. |
| **Alice** | She's right! |
| **Osvaldo** | Not you too. Don't tell me you like to bathe with a raincoat on. |
| **Alice** | There is a lot of disease around, and *Jeito* protects us. |
| **Osvaldo** | But do I look sick to you? |
| **Alice** | There are diseases that you can't see. Even a person that looks healthy could be infected. |
| **Osvaldo** | OK Alice. We will think about it. |
| **Alice** | Yes my darling, but we will think with *Jeito*. |
| **Announcer** | Let's open our eyes. Let's use *Jeito*. A packet of 4 condoms for only 500 Meticais. On sale near you. |

***Table 14: Music for Spots***

| | | |
|---|---|---|
| **Rap 1** | Faça amor mas so com *Jeito (make love, but only with Jeito [style])* | 35" |
| **Rap 2** | Essa mania da camisinha *(this craze of the condom)* | 35" |
| **Rap 3** | Eu sou *jeitoso (I am stylish / capable)* | 35" |